BURNS & ASSOCIATES, INC.

Health Policy Consultants

INDEPENDENT EVALUATION OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

FINAL REPORT

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TABLE OF CONTENTS

Executive Summary

Chapter I: Review of the National State Children's Health Insurance Program and How Indiana's CHIP Compares to Other State Programs
- SCHIP and Its Impact on Reducing the Rate of Uninsured Children I-1
- Issues Surrounding the Reauthorization of SCHIP I-4
- Indiana's CHIP at a Glance I-5
- How Indiana's CHIP Operations Compare to Other State's Programs I-6
- Program Changes Affecting Indiana's CHIP in 2006 and Early 2007 ..... I-8
- Focus of this Evaluation I-9

Chapter II: Enrollment in Indiana's CHIP
- Enrollment Growth in the Last Five Years II-2
- Length of Enrollment II-3
- Reasons for Disenrollment II-4
- Enrollment by Service Delivery System II-5
- Enrollment by MCO Within Managed Care II-7
- Enrollment by Age II-9
- Enrollment by Race II-10
- Enrollment by Region II-10

Chapter III: Access to Services
- Introduction III-2
- Availability of Pediatricians III-2
- Evaluating the Potential Impact of Panel Size Issues on Access III-6

Chapter IV: Utilization of Services in Indiana's CHIP
- Introduction IV-3
- Methodology IV-3
- Services Studied IV-4
- Findings IV-5

Chapter V: Prevalence & Utilization of Children with Specific Diagnoses in Indiana's CHIP
- Introduction V-2
- Prevalence V-2
- Services Studied V-3

Chapter VI: Comparisons to National Benchmarks
- Introduction VI-2
- EPSDT Survey VI-3
- HEDIS Measures VI-7
- CAHPS Medicaid Child Member Satisfaction Survey VI-14

Chapter VII: Expenditures in Indiana's CHIP

Chapter VIII: Recommendations to Indiana's CHIP

Listing of Exhibits

Exhibit I.1 Comparison of Child Uninsured Rates: Indiana to US

Exhibit I.2 Changes in SCHIP Enrollment: Indiana to US

Exhibit I.3 Indiana Children in Families Under 200% of Federal Poverty Level

Exhibit I.4 Uninsured Rate Among Children in Families Below 200% of Federal Poverty Level

Exhibit II.1 5-Year Enrollment Patterns in Indiana's CHIP

Exhibit II.2 Calculation of Member Disenrollment Rate

Exhibit II.3 CHIP A Length of Enrollment, For Children Enrolled Before July 2006, Children Who Turned Age 19 are Excluded

Exhibit II.4 CHIP C Length of Enrollment, For Children Enrolled Before July 2006, Children Who Turned Age 19 are Excluded

Exhibit II.5 Potential Reason for Disenrollment

Exhibit II.6 Enrollment in Entire CHIP Program by Delivery System

Exhibit II.7 Children Who Have Remained in Fee-for-Service Beyond 30 Days

Exhibit II.8 Distribution of CHIP A Members by MCO, Average Across Calendar Year 2006

Exhibit II.9 Distribution of CHIP C Members by MCO, Average Across Calendar Year 2006

Exhibit II.10 Distribution of CHIP A Members by MCO, March 2007

Exhibit II.11 Distribution of CHIP C Members by MCO, March 2007

Exhibit II.12 Distribution of CHIP A Members by Age, Average Across Calendar Year 2006

Exhibit II.13 Distribution of CHIP C Members by Age, Average Across Calendar Year 2006

Exhibit II.14 Comparison of CHIP Members by Race to Statewide Child Population

Exhibit II.15 CHIP Enrollment Per 1,000 Children By County

Exhibit III.1 Availability of Pediatricians and Family Practitioners in the County

Exhibit III.2 Panel Capacity for PMPs Who Accept Children

Exhibit III.3 Correlation Analysis Across Access and Utilization Measures

Exhibit III.4 Percent of Members Who Visited Their Assigned PMP

Exhibit III.5 Percent of Members Who Visited an Unassigned PMP

Exhibit III.6 Percent of Members Who Had an Emergency Room Visit

Exhibit IV.1 Utilization Statistics in CHIP A and CHIP C, Statewide Totals

Exhibit IV.2 Utilization Statistics for CHIP Package A Children in 2006, By Age Group

Exhibit IV.3 Utilization Statistics for CHIP Package C Children in 2006, By Age Group

Exhibit IV.4 Utilization Statistics for CHIP Package A Children in 2006, By MCO

Exhibit IV.5 Utilization Statistics for CHIP Package C Children in 2006, By MCO

Exhibit IV.6 Utilization Statistics in CHIP A and CHIP C, Statewide Totals, New Enrollees

Exhibit IV.7 Utilization Statistics for CHIP A New Enrollees in 2006, By Age Group

Exhibit IV.8 Utilization Statistics for CHIP C New Enrollees in 2006, By Age Group

Exhibit V.1 Utilization Statistics in CHIP A and CHIP C, Members with and without Asthma Diagnoses

Exhibit V.2 Utilization Statistics in CHIP A and CHIP C, Members with and without Behavioral Diagnoses

Exhibit V.3 Utilization Statistics in CHIP A and CHIP C, Members with and without Obesity Diagnoses

Exhibit VI.1 Participant Ratio for EPSDT Services- 2006

Exhibit VI.2 Screening Ratio for EPSDT Services- 2006

Exhibit VI.3 Participant Ratio for EPSDT Services- 2005

Exhibit VI.4 Screening Ratio for EPSDT Services- 2005

Exhibit VI.5 Participant Ratio for EPSDT Services- 2005

Exhibit VI.6 Screening Ratio for EPSDT Services- 2005

Exhibit VI.7 Rates for Combination Two Immunizations

Exhibit VI.8 Rates for Treatment of Respiratory Infections & Testing Pharyngitis

Exhibit VI.9 Use of Appropriate Medications for People with Asthma

Exhibit VI.10 Children's Access to Primary Care Practitioners, Age 12-24 Months and Age 25 Months-6 Years

Exhibit VI.11 Children's Access to Primary Care Practitioners, Age 7-11 Years and Age 12-19 Years

Exhibit VI.12 Well Child Visits (Infants)

Exhibit VI.13 Well Child Visits (Non-Infants)

Exhibit VI.14 Summary of Demographic Information from 2006 Member Surveys

Exhibit VI.15 Summary of Responses from 2006 Member Surveys

Exhibit VII.1 Trends in Expenditures for CHIP A and CHIP C

Exhibit VII.2 Trends in Cost Per Member Per Month, Total Federal and State Share

Exhibit VII.3 Trends in Cost Per Member Per Month, State Share Only

Executive Summary

Since 1997, the State Children's Health Insurance Program (SCHIP) has been instrumental in lowering the uninsured rate for children in families below 200% of the federal poverty level (FPL) from 23% in 1997 to 14% in 2005. Indiana took the option used in 20 other states as well by designing its CHIP into two categories. A Medicaid expansion portion (called CHIP Package A in Indiana), covers children in families with incomes up to 150% of the FPL ($24,900 per year for a family of three in 2006) who are not already eligible for Medicaid. The State-designed portion (called CHIP Package C in Indiana) covers children in families with incomes above 150% up to 200% of the FPL ($33,200 per year for a family of three in 2006). In December 2006, there were 53,162 children enrolled in Indiana's CHIP Package A and 18,343 children enrolled in CHIP Package C for a total of 71,505 children.

The growth rates are slowing in both CHIP Package A and C. In fact, Calendar Year (CY) 2006 was the first year that CHIP C did not post a year-over-year gain. Enrollment in CHIP C hit its high point in January 2006 at 18,743 members. Premiums charged to families were doubled in February 2006 and this appears to have had some impact on enrollment. As of March 2007, enrollment was back near its all-time high (18,535 members). CHIP A has consistently posted modest growth in each of the past five years (5%-6%), but in 2006 enrollment was basically flat (increase of 0.8%).

Indiana's CHIP has assisted the State exceed other states in reducing the rate of uninsured children. Indiana's uninsured rate of 9.6% for all children in 2004-2005 was better than the national average of 11.4% (ranked 30th among all states and DC). Among low-income children (families less than 200% of poverty), Indiana's uninsured rate of 14.0% for children is also better than the national average of 19.3% (ranked 17th among all states and DC). Indiana has the same percentage of children in low-income families as the national average (43%), and provides insurance to about the same percentage of children as the national average in the Medicaid/SCHIP programs.

The success of Indiana's CHIP has certainly contributed to the State's ability to keep the number of uninsured children in the state from growing despite increases in the overall child population. For example, although the number of children in low-income families has increased from 534,000 to 640,000 in the last five years, Indiana has been able to keep the number of uninsured children in this group constant at just under 100,000.

Indiana CHIP Operations

Within the State, Indiana's CHIP is seamlessly integrated into Hoosier Healthwise, the managed care portion of Indiana's Medicaid program. As such, CHIP enrollees have the same access to providers as all other Medicaid managed care members including choice of primary medical provider (PMP). There is no difference in the

access to or ability to provide services between CHIP members and children in Hoosier Healthwise.

In 2006, CHIP members were enrolled in one of five managed care organizations (MCOs), some of which were regional and some were statewide. Contracting changes within Hoosier Healthwise means that as of January 2007, CHIP members are enrolled in one of three MCOs, all of which serve Hoosier Healthwise members statewide. It was found that children seamlessly moved from the five MCOs in 2006 to the three MCOs now available in 2007. There does appear, however, to be a smaller subset of children that have remained in the Fee-for-Service delivery system beyond the original 30 days that is expected. This needs further exploration from the CHIP Office.

Access to primary care does not appear to be an issue for children in Indiana's CHIP. A disproportionate use of hospital emergency rooms or other non-office settings suggests that an area may be lacking adequate primary care resources. Although there are 34 counties in the state that do not have a pediatrician contracted with the Hoosier Healthwise program to serve Medicaid and CHIP children, all but two of these have family practitioners available to serve children. The other two have general practitioners that will serve children.

Even where physicians are available, each will contract with the State as to how many Medicaid/CHIP children they will accept. This is referred to as "panel capacity". There does not appear to be a relationship between counties with full or near-full panel capacity and CHIP members' access to primary care. In fact, in four of the six counties with potential panel capacity issues, the percentage of CHIP members that saw their primary medical provider (PMP) in 2006 was above the statewide average. It was also found that none of the full/near-full panel counties had a disproportionate volume of hospital ER usage among CHIP members.

CHIP A and CHIP C members who were enrolled for at least nine months in the year were studied to determine if they had used 11 different types of services available to them. In all 11 cases, in both CY 2005 and CY 2006, there were a higher percentage of CHIP C children utilizing each service than the percentage of CHIP A children. Significant differences were found in the percentage of children that see their PMP, those that saw another PMP not assigned to them, those that had a prescription, and those that had an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) examination.

The same study of children enrolled at least nine months was conducted to compare CHIP members to children in traditional Medicaid. In 10 out of 11 services studied, a higher percentage of CHIP children used services than Medicaid children. The one service where Medicaid children had higher utilization was inpatient hospital, but this is because the vast majority of infants are in Medicaid and their stay when they are born is counted as an inpatient stay.

There were significant differences between the percentage of CHIP children and Medicaid children who saw their assigned PMP (72% of CHIP A children, 83% of CHIP C children, 60% of Medicaid children in 2006) or who had a preventive dental visit (68% of CHIP A children, 71% of CHIP C children, 48% of Medicaid children). The utilization of EPSDT services was similar between CHIP and Medicaid children.

The percentage of children utilizing each service was also compared by age group and for members enrolled with each MCO as compared to the statewide averages. Relatively speaking, the percentage of children utilizing each service was similar across age groups, with some anticipated differences in some areas. Among the MCOs, one common trend found was that children enrolled with CareSource were less likely to use most services than their counterparts in other MCOs. However, this is one of the MCOs that stopped providing services to Hoosier Healthwise children at the end of 2006. With the exception of CareSource, the other four MCOs had similar results on the percentage of children who saw their PMP.

Indiana CHIP Expenditures

Total payments made by the State for services for children in the premium-based portion of CHIP (CHIP C) were flat in CY 2006. When accounting for the premiums paid by families of children in CHIP C and federal financing participation, the final cost to the State for this group was only $19.88 on a per member per month (PMPM) basis.

Payments for children in the no-premium portion of CHIP (CHIP A) increased 9% in CY 2006. On a PMPM basis (total federal and state cost), CHIP C children have cost the State about 20% less than CHIP A children in the last three years. The figures were $27.19 and $34.80, respectively, in CY 2006. But CHIP A children are also 20% less costly than children in traditional Medicaid ($62.22 in CY 2006).

In CY 2004, two-thirds of all payments made for CHIP services were on a fee-for-service basis. In CY 2006, two-thirds of all payments were made on a capitated PMPM basis through the Risk-Based Managed Care (RBMC) delivery system. Key services that were still made on a fee-for-service basis were dental and behavioral health related services. Starting in 2007, however, behavioral health services will also be part of the RBMC monthly capitation payment.

SCHIP Going Forward

There is considerable debate at the federal level presently regarding how much to fund an extension of SCHIP. Fortunately, Indiana may not be impacted by many of the items currently being debated. Indiana's CHIP, like 24 other states, caps eligibility at 200% of the Federal Poverty Level, and the State only covers children and not other populations (e.g. their parents) in its CHIP. These are both provisions in the President's budget for SCHIP. The SCHIP enjoys bipartisan support, but the current debate is centered around financing and growing the program. The President's budget is allocating an additional $4.8 billion in funds over the next five

years, while Democrats are seeking an additional $50 billion over the same time period.

In Federal Fiscal Year 2006, Indiana's match rate was 74.09%. Indiana has historically been in the middle of match rates when comparing all states nationwide. This means that for every dollar spent by Indiana on its CHIP, the federal government reimburses the State 74.09 cents. The question of how to determine match rates going forward for SCHIP is also up for debate and this has been a contentious issue over its 10-year period.

About This Evaluation

Burns & Associates, Inc. (B&A), a health care consulting firm, was contracted to conduct this year's independent evaluation. This report covers our evaluation of enrollment trends, access to services, use of services by members, the quality of services delivered and members' satisfaction with the program, and comparisons of Indiana's CHIP to national benchmarks. At the beginning of each chapter, a section titled "Chapter Highlights" provides a quick summary of the discussion within the chapter. Chapter VIII offers B&A's recommendations to the State in the areas of financing, enrollment, access, service utilization, and quality of its CHIP. Our overall impression is that the CHIP is meeting its goals of providing cost-effective services to children who, in the absence of the program, would most likely be uninsured and have an unmet need.

I. Review of the National State Children's Health Insurance Program and How Indiana's CHIP Compares to Other State Programs

SCHIP and Its Impact on Reducing the Rate of Uninsured Children

By most accounts, the federal State Children's Health Insurance Program (SCHIP) has been successful in providing insurance to low-income children who were not eligible for Medicaid previously or who had been eligible but, due to targeted outreach, had not enrolled prior to the implementation of SCHIP. Since it was passed as part of the Balanced Budget Act of 1997, the SCHIP has been instrumental in lowering the uninsured rate for children in families below 200% of the federal poverty level (FPL) from 23% in 1997 to 14% in 2005. This reduction also held true by racial/ethnic groups. The uninsured rate for Hispanic children fell from 33% to 27%; for African American children, from 22% to 15%; and for White children, from 20% to 14%.[1]

The Centers for Medicare and Medicaid Services (CMS) reports that about six million children were covered by SCHIP at some point in federal fiscal year 2005. States had the option of creating a Medicaid expansion (1.7 million enrollees in 2005), a state-designed program (4.4 million enrollees in 2005), or both. In a typical month in 2005, there were approximately four million children covered in SCHIP.[2]

Indiana's CHIP is deemed a combination program based on how it was originally structured, the same option adopted by 20 other states. There are two main components to the program. The Medicaid expansion portion (called CHIP Package A in Indiana) covers children in families with incomes up to 150% of the FPL ($24,900 per year for a family of three in 2006) who are not already eligible for Medicaid. The State-designed portion (called CHIP Package C in Indiana) covers children in families with incomes above 150% up to 200% of the FPL ($33,200 per year for a family of three in 2006). In December 2006, there were 53,162 children enrolled in Indiana's CHIP Package A and 18,343 children enrolled in CHIP Package C for a total of 71,505[3] children.

Despite improvements in the uninsured rate for children in the last ten years, it is estimated that nine million children remain uninsured (11.4% of children nationwide). Three out of four of these children are eligible for Medicaid or SCHIP but are not enrolled, and more than 96% of the children are U.S. citizens. Despite considerable growth in Indiana's CHIP in the last five years, it is estimated that in 2005 there were 161,280 uninsured children (9.6% of children statewide). Of these, 101,136 (63%) are eligible for Medicaid or CHIP.[4] This means that there is

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[1] Leighton Ku, Mark Lin, and Matthew Broaddus. "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP, 2007 Edition," Center on Budget and Policy Priorities, January 2007

[2] Ibid.

[3] Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on April 24, 2007.

[4] "A Decade of SCHIP Experience and Issues for Reauthorization," The Kaiser Commission on Medicaid and the Uninsured, January 2007

considerable opportunity for growth in Indiana's CHIP under current eligibility guidelines.

Indiana's CHIP, however, has exceeded other states in reducing the rate of uninsured children. Indiana's uninsured rate of 9.6% for all children in 2004-2005 was better than the national average of 11.4% (ranked 30th among all states and DC). Among low-income children (families less than 200% of poverty), Indiana's uninsured rate of 14.0% for children is also better than the national average of 19.3% (ranked 17th among all states and DC). Indiana has the same percentage of children in low-income families as the national average (43%), and provides insurance to about the same percentage of children as the national average in the Medicaid/SCHIP programs.[5]

Exhibit I.I
Comparison of Child Uninsured Rates: Indiana to US

	Percent Covered by Medicaid/SCHIP	Percent Uninsured
Health Insurance Coverage: All Children (2004-2005)		
U.S. (77.8 million)	26.3%	11.4%
Indiana (1.68 million)	26.8%	9.6%
Health Insurance Coverage: Low-Income Children (2004-2005)		
U.S. (42.7% of all children)	50.4%	19.3%
Indiana (43.0% of all children)	53.2%	14.0%

Based on the last three years that data is available, Indiana has been more successful than SCHIP programs nationally in enrolling children in its CHIP. It ranks 26th in enrollment growth from 2004 to 2005 across all states and DC.[6]

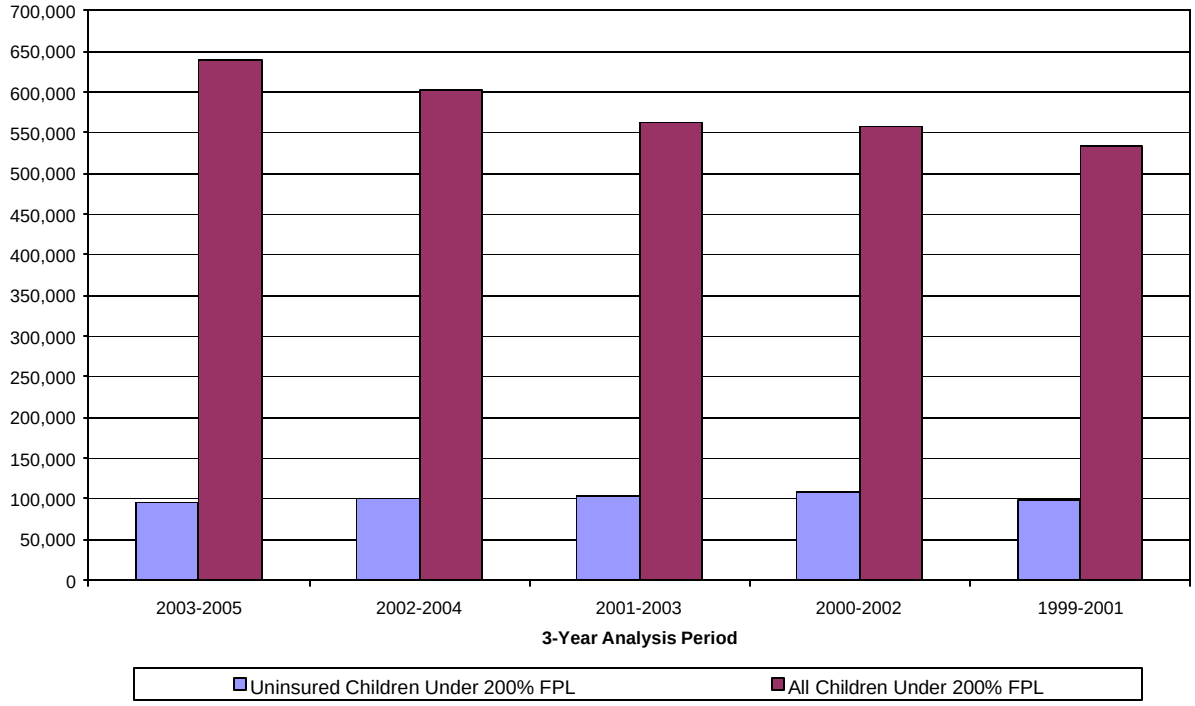
Exhibit I.2
Changes in SCHIP Enrollment: Indiana to US

	Pct Change June 02 to June 03	Pct Change June 03 to June 04	Pct Change June 04 to June 05
U.S.	9.6%	-1.4%	2.2%
Indiana	17.7%	13.2%	7.0%

[5] Karyn Schwartz and Cathrin Hoffman. "Health Insurance Coverage of America's Children," The Kaiser Commission on Medicaid and the Uninsured, January 2007
[6] Vernon Smith, David Rousseau and Caryn Marks. "SCHIP Program Enrollment: June 2005 Update,", The Kaiser Commission on Medicaid and the Uninsured, December 2006

The success of Indiana's CHIP has certainly contributed to the State's ability to keep the number of uninsured children in the state from growing despite increases in the overall child population. For example, although the number of children in low-income families has increased from 534,000 to 640,000 in the last five years, Indiana has been able to keep the number of uninsured children in this group constant at just under 100,000.[7]

Exhibit I.3
Indiana Children in Families Under 200% of Federal Poverty Level

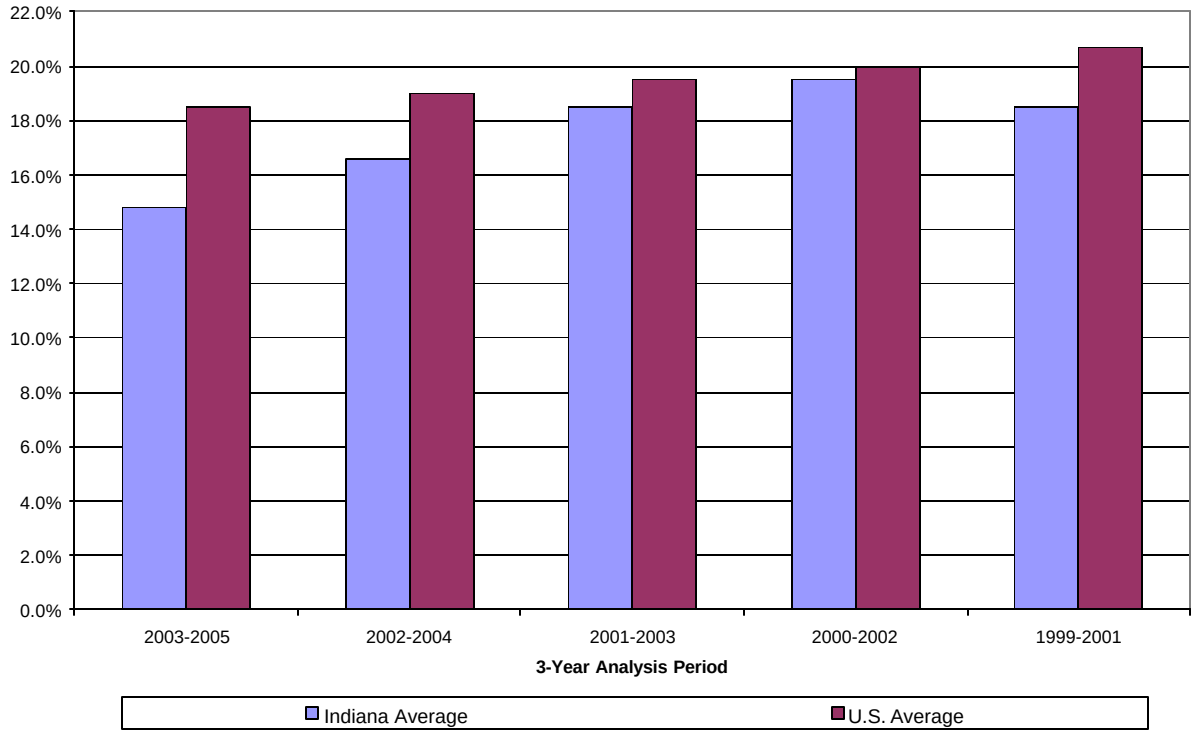


The impact of CHIP enrollment, other Hoosier Healthwise program enrollment, and private insurance coverage has enabled Indiana to maintain an uninsured rate that is below the national average for children in low-income families in each of the last five study periods (see Exhibit I.4 on the next page).[8]

[7] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Number and Percent of Children under 19 Years of Age, at or below 200 Percent of Poverty. Counts of children in each 3-year analysis period reflect an average of the figures computed for each year individually. http://www.census.gov/hhes/www/hlthins/lowinckid.html

[8] Ibid.

Exhibit I.4
Uninsured Rate Among Children in Families Below 200% of Federal Poverty Level



Issues Surrounding the Reauthorization of SCHIP

There is considerable debate at the federal level presently regarding how much to fund an extension of SCHIP, which expires September 30, 2007. The key issues that are being debated include:

- Whether to fund the existing SCHIP population without room for growth in the program or to fund for growth to outreach to the over six million Medicaid/SCHIP eligibles currently not enrolled
- Whether to limit any SCHIP funding to enrollees to children in families below 200% of the poverty level
- Whether to limit SCHIP funding to cover children through age 18 only, even though some states were granted federal authority to cover pregnant women, parents, and childless adults with SCHIP dollars
- The formula to allocate whatever funding is authorized, given the widespread critique of how funds were allocated in the initial 10-year period
- The flexibility given to states to retain unspent SCHIP dollars allocated for a given federal fiscal year to use in future years

These issues not only affect SCHIP's future, but also affect coverage in the last year of the initial authorization. The federal allocation for SCHIP in its first 10 years was $40 billion. Despite numerous redistributions of dollars from "fund-rich" to "fund-poor" states over the years, just over $1 billion in unspent SCHIP funds reverted back to the federal treasury in 2004 because of time restrictions as to when states could spend their SCHIP allocations.[9] Even with enactment of legislation to curtail expected shortfalls, 14 states were expected to run out of money to cover current enrollment in 2007 for a total of $716 million.[10] Funding for this shortfall was included in a war funding bill that was signed by the President in the Spring.

Fortunately, Indiana may not be impacted by many of the items currently being debated. Indiana's CHIP, like 24 other states, caps eligibility at 200% of the FPL (another 17 states cover children above this level up to as high as 350% of the FPL). The State only covers children and not other populations. The most recent data predicts that Indiana is 8th highest among states with available reserve dollars in its federal SCHIP allotment. Even in this last year of the current authorization, when 37 states are expected to spend more in 2007 than they were allotted for the year from the federal government, Indiana is expected to have a reserve from its 2007 allotment.[11] What remains uncertain is how much Indiana will receive in the SCHIP reauthorization and whether the State will be able to retain its present reserve fund.

The SCHIP enjoys bipartisan support, but the current debate is centered around financing and growing the program. The President's budget is allocating an additional $4.8 billion in funds over the next five years[12], while Democrats are seeking an additional $50 billion over the same time period. The Congressional Budget Office estimates the figure at $4.6 billion, but it assumes changes in SCHIP policy which would reduce enrollment in the program from current figures (e.g. to limit enrollment to children in families up to 200% of the Federal Poverty Level).[13] The Children's Health Fund estimates that an additional $13 billion is required just to maintain coverage for those children and parents already enrolled in the program.[14]

Indiana's CHIP at a Glance

As in the Medicaid program, SCHIP is funded jointly by the federal government and state governments. In an effort to encourage enrollment, the federal government offers an enhanced match rate for every dollar spent to cover enrollees in SCHIP. A state cannot receive less than 65 cents or more than 85 cents for every state dollar spent. Match rates are based on estimates of low-income and uninsured children in each state, as tabulated in the Current Population Survey which is conducted by the

[9] "A Decade of SCHIP Experience and Issues for Reauthorization," The Kaiser Commission on Medicaid and the Uninsured, January 2007
[10] Ibid.
[11] Ibid.
[12] "President's FY 2008 Budget and the State Children's Health Insurance Program", The Kaiser Commission on Medicaid and the Uninsured, April 2007
[13] Ibid.
[14] http://www.childrenshealthfund.org/whatwedo/safetynet.php, retrieved March 16, 2007

U.S. Census Bureau. In Federal Fiscal Year 2006, Indiana's match rate was 74.09%. Indiana has historically been in the middle of match rates when comparing all states nationwide. This means that for every dollar spent by Indiana on its CHIP, the federal government reimburses the State 74.09 cents.

Because CHIP Package C is the state-designed portion of the program, the State opted to impose premiums for families with incomes at or above 150% of the FPL. The premium amount varies by the income level and the number of children covered in the family. For families with one child covered, the premium range is from $22 to $33 per month; for families with two or more children covered, the premium range is from $33 to $50. Also, there are some co-pay requirements in CHIP Package C that are not required in CHIP Package A, such as for prescriptions ($3 co-pay for generic drugs and $10 for brand name drugs).

Within the State, Indiana's CHIP is seamlessly integrated into Hoosier Healthwise, the managed care portion of Indiana's Medicaid program. As such, CHIP enrollees have the same access to providers as all other Medicaid managed care members including choice of primary medical provider (PMP). There is no difference in the access to or ability to provide services between CHIP members and children in Hoosier Healthwise. In 2006, CHIP members were enrolled in one of five managed care organizations (MCOs), some of which were regional and some were statewide. Contracting changes within Hoosier Healthwise means that as of January 2007, CHIP members are enrolled in one of three MCOs, all of which serve members statewide.

The operation of Indiana's CHIP is shared among divisions of the State's Family and Social Services Administration (FSSA), with primary functions provided by the Office of Medicaid Policy and Planning (OMPP), the designated single state agency charged with administering Hoosier Healthwise, and the Division of Family Resources, which conducts CHIP eligibility determination.

How Indiana's CHIP Operations Compare to Other State's Programs

With respect to the services offered, Indiana has opted to provide its CHIP members with services very similar to those offered other children in Hoosier Healthwise, with a few limitations. This is a practice seen in other states as well. The types of services offered CHIP members are also like those offered in other state programs, including:

- Hospital Care
- Doctor Visits
- Check Ups
- Well-child Visits
- Clinic Services
- Prescription Drugs
- Lab and X-ray Services
- Mental Health Care
- Substance Abuse Services
- Medical Supplies and Equipment
- Home Health Care
- Dental Care
- Vision Care
- Therapies
- Hospice Care
- Transportation (some limits)
- Family Planning Services
- Nurse Practitioner Services
- Nurse Midwife Services
- Foot Care (some limits)
- Chiropractors

A significant reason why Indiana's CHIP has been as successful as it has is due to the State's initial outreach efforts and its intent to encourage enrollment through eliminating red tape where possible. Other states also took this approach, though many did not at the outset like Indiana had. Some of the aspects of the program that Indiana designed that may have encouraged enrollment are shown below.[15]

Design Aspect	Adopted by Indiana?	Adopted by other states?
Do not require a face-to-face interview to apply	Yes	46 states
Joint application for Medicaid and CHIP	Yes	33 of 36 states with State-only programs
Ability to renew coverage annually	Yes	44 states
Disregard assets in determining child's eligibility	Yes	46 states
"Going bare" period (must be uninsured before enrolling)	3 months	34 states require a waiting period (11 use 3 months, 16 use 6 months)
Continuous eligibility for 12 months, regardless of change in circumstances	Indiana has continuous eligibility for 6 months	16 states have continuous eligibility
Co-payments required for non-preventive physician, emergency room, and/or inpatient hospital stay	$0	33 states have $0 co-payments
Co-payments required for prescription drugs	$3 (generic), $10 (brand)	21 states require co-payments
Premiums required	$0 up to 150% FPL; required above this FPL	11 of 35 states require at 100% FPL; 26 of 35 states require at 150% FPL; 28 of 35 states require at 200% FPL

Program Changes Affecting Indiana's CHIP in 2006 and Early 2007

It is perceived that the change in MCOs in the Hoosier Healthwise program should have no impact on enrollment for current members, but this will be verified later in the evaluation. Some other programmatic changes, however, may affect enrollment of children in CHIP. These include:

(1) *Proof of citizenship*. Since July 1, 2006, most Medicaid and CHIP-eligible applicants or renewed enrollees are required to provide documentation of their citizenship status. Prior to this, most states only required attestation from the applicant in writing. This does not apply to immigrants, since most new legal immigrants are not eligible for public programs in their first

[15] Donna Cohen Ross, Laura Cox and Caryn Marks. "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," The Kaiser Commission on Medicaid and the Uninsured, January 2007

five years in the U.S. and undocumented immigrants are only eligible for emergency services. This policy change has counteracted states' efforts to streamline the eligibility and application process. Although a relatively new policy, a number of states are reporting enrollment declines and backlogs of applications because eligibility workers need to spend more time on each case.[16]

(2) *CHIP Package C Premiums*. In February 2006, the premiums charged to members in CHIP Package C doubled. The annual amount of the premium for two children in a family at 200% of the FPL is now $600. Of the 34 states with programs serving members at this FPL, 28 charge premiums. Indiana's increases places the state in the upper quartile of those states that charge premiums.[17] The impact of this change on enrollment and renewals is discussed in Chapter II.

(3) *Modernization Project*. The FSSA is implementing a change throughout 2007 in the design of how case workers are assigned to Hoosier Healthwise members. In the new format, a single case worker is no longer assigned to a particular member or eligible. Since this change is just starting, an analysis of its impact will occur in next year's evaluation.

Focus of this Evaluation

Burns & Associates, Inc. was hired by the FSSA to conduct this annual evaluation of CHIP Package A and CHIP Package C. The remainder of this report provides an in-depth analysis of various aspects of the program:

- Chapter II: Enrollment
- Chapter III: Access to Services
- Chapter IV: Utilization of Services
- Chapter V: Prevalence and Utilization of Services of CHIP Members with Asthma, Behavioral Health Conditions, and Incidence of Obesity
- Chapter VI: Comparisons to National Benchmarks
- Chapter VII: Expenditures in CHIP
- Chapter VIII: Recommendations to Indiana's CHIP

At the beginning of each chapter, a section titled "Chapter Highlights" provides a quick summary of the discussion within the chapter.

[16] Ibid.
[17] Ibid.

II. Enrollment in Indiana's CHIP

Chapter Highlights

- Although Indiana's CHIP has grown in enrollment by 35% (over 18,000 members) in the last five years, enrollment in 2006 was flat for both CHIP Package C and only modest growth for CHIP Package A.

- Disenrollment of members has been and continues to be high in the program. In 2006, the disenrollment rate was 17% for CHIP A and 25% for CHIP C (excluding from the analysis children who are automatically disenrolled when they turn age 19).

- Despite high turnover, there is a significant portion of the population who remains in the program for a significant period of time. Once again excluding those that turned age 19 during the year, 55% of CHIP A children and 45% of CHIP C children have been enrolled in the program for more than four years.

- The CHIP Office may want to explore further why children are disenrolling from the program. Parents must reapply every 12 months to ensure that their children are still eligible for CHIP. Burns & Associates (B&A) did not see an obvious spike in disenrollments after a child has been enrolled for 12 months (implying that their parents did not reapply), but the State does not have sufficient documentation to track why members are leaving (e.g. parents obtained private insurance, parents' income has exceeded eligibility threshold, moved out of state, etc.)

- CHIP members enroll with one of the Hoosier Healthwise managed care organizations (MCOs). For a short period, members may be in the Fee-for-Service (FFS) delivery system for one month before they select their primary medical provider (PMP) or one is selected for them. B&A found, however, that 12% of children in CHIP A and 8% of children in CHIP C have remained in FFS beyond one month. This is an area that should be further researched by CHIP Office staff.

- B&A found that children successfully moved to one of the three MCOs in place effective January 2007 after three of the MCOs in 2006 discontinued service.

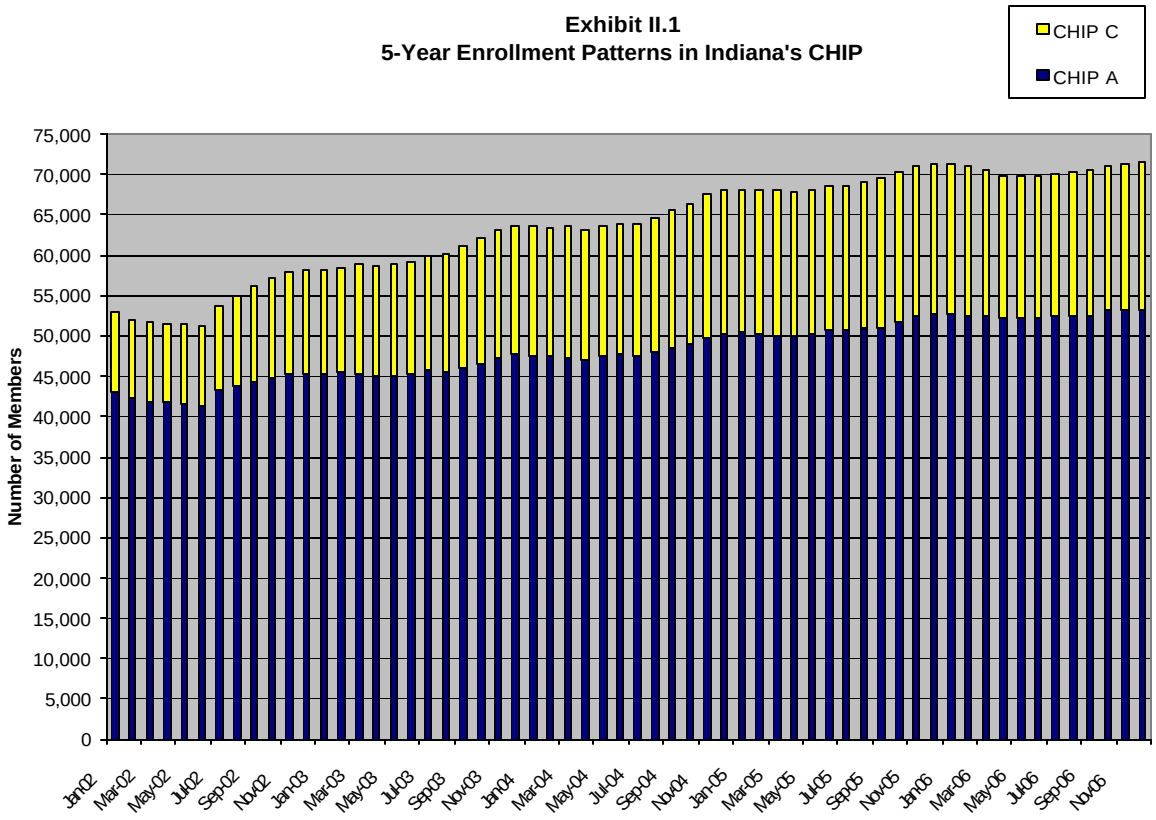
- Younger children are more represented in CHIP C than in CHIP A. This is mostly due to Hoosier Healthwise eligibility criteria for traditional Medicaid which differs by age. Minorities are disproportionately represented in Indiana's CHIP, which is similar to what is found in the Medicaid program.

- There is not a clear over-representation of CHIP members in urban or rural settings. The ratio of CHIP enrollees to the overall child population varies widely by county.

Enrollment Growth in the Last Five Years

As of December 2006, Indiana's CHIP Package A (family income up to 150% of federal poverty level) enrollment was 53,162. Indiana's CHIP Package C (family income up to 200% of the federal poverty level) was 18,343. The entire CHIP has grown 35% (18,658 members) in the last five years. CHIP Package A has grown 24%, while CHIP Package C growth has almost doubled. Due to the small enrollment in CHIP Package C five years ago, however, the actual gain in members for each portion of the CHIP is similar (10,200 in CHIP A and 8,458 in CHIP C).

Exhibit II.1
5-Year Enrollment Patterns in Indiana's CHIP



The growth rates are slowing in both CHIP Package A and C. In fact, CY 2006 was the first year that CHIP C did not post a year-over-year gain. Enrollment in CHIP C hit its high point in January 2006 at 18,743 members. Premiums charged to families were doubled in February 2006 and this appears to have had some impact on enrollment. As of March 2007, enrollment was back near its all-time high (18,535 members). CHIP Package A has consistently posted modest growth in each of the past five years (5%-6%), but in 2006 enrollment was basically flat (increase of 0.8%).

Member disenrollment continues to be high in both programs. For example, the actual enrollment in Indiana's CHIP was 71,505 at the end of 2006, but the number of children ever enrolled at a point in time in 2006 in either CHIP was 140,817. This number is misleading, however, because children transition quite a bit between the

two CHIP programs and the Medicaid program based changes in their eligibility. There were 32,934 children who were enrolled in CHIP at some point in 2006 but who were enrolled in Medicaid at the end of the year. Likewise, there were 9,396 children who started in CHIP A but moved to CHIP C, or vice versa. The actual number of children who were enrolled in CHIP at some point in 2006 but disenrolled from Hoosier Healthwise completely is 26,990. This yields a disenrollment rate of 17% for CHIP A and 25% for CHIP C.

Exhibit II.2
Calculation of Member Disenrollment Rate

	CHIP A	CHIP C
Ever Enrolled- CY 2006	103,556	37,261
Which is broken down into:		
Enrollment- Dec 2006	53,162	18,343
Moved to Medicaid	27,815	5,119
Moved to other CHIP program	5,042	4,354
Disenrolled from Hoosier Healthwise	17,357	9,445
Disenrollment rate = (Disenrolled divided by ever enrolled)	17%	25%

Children are placed in the program that maximizes their benefit package and also minimizes payment requirements to their parents for premiums or co-pays. But because Medicaid and CHIP are part of the same Hoosier Healthwise delivery system, children do not need to change doctors when they move between CHIP and Medicaid.

Length of Enrollment

Despite the high disenrollment rate, there are a significant number of children in both CHIP A and CHIP C who have remained continuously enrolled for a long period of time. B&A analyzed the group of children who were enrolled before July 2006 to determine how long they were enrolled in the program (measured in number of months through December 2006). Eligibility rules dictate that children must be disenrolled from either CHIP A or CHIP C the month after they turn age 19. Therefore, this subgroup was removed so that the results are not skewed. We found that 55% of CHIP A children and 45% of CHIP C children have been enrolled for more than four years. Among this population, 95% of children have been enrolled for one year or more.

Exhibit II.3
CHIP A Length of Enrollment
For Children Enrolled Before July 2006
Children Who Turned Age 19 are Excluded

Number of Months Enrolled (through Dec 2006)	CHIP A Disenrolled by Dec 2006	CHIP A Still Enrolled in Dec 2006	CHIP A Total	Percent of Total
1 to 6 months	1	67	68	0.1%
6 to 12 months	62	2,366	2,428	4.9%
13 to 18 months	105	2,983	3,088	6.2%
19 to 24 months	91	2,903	2,994	6.0%
25 to 30 months	97	3,061	3,158	6.3%
31 to 36 months	98	3,149	3,247	6.5%
37 to 42 months	112	3,440	3,552	7.1%
43 to 48 months	104	3,526	3,630	7.3%
49 or more months	468	27,187	27,655	55.5%
All Members	**1,138**	**48,682**	**49,820**	**100.0%**

Exhibit II.4
CHIP C Length of Enrollment
For Children Enrolled Before July 2006
Children Who Turned Age 19 are Excluded

Number of Months Enrolled (through Dec 2006)	CHIP C Disenrolled by Dec 2006	CHIP C Still Enrolled in Dec 2006	CHIP C Total	Percent of Total
1 to 6 months	1	37	38	0.2%
6 to 12 months	75	1,026	1,101	5.9%
13 to 18 months	78	1,596	1,674	9.0%
19 to 24 months	78	1,456	1,534	8.2%
25 to 30 months	88	1,445	1,533	8.2%
31 to 36 months	72	1,400	1,472	7.9%
37 to 42 months	66	1,405	1,471	7.9%
43 to 48 months	77	1,404	1,481	8.0%
49 or more months	267	8,044	8,311	44.6%
All Members	**802**	**17,813**	**18,615**	**100.0%**

Reasons for Disenrollment

In addition to the “aging out”clause, all children must reapply after having been enrolled for 12 months to determine if they are still eligible based on their family income.

B&A reviewed the records of all members who disenrolled from CHIP in 2006 to determine if it was evident why they left the program.

Exhibit II.5
Potential Reason for Disenrollment

	CHIP A	CHIP C
Total Disenrolled from Hoosier Healthwise in 2006 *	13,331	8,880
"Aged out" (turned 19)	1,338 (10%)	223 (3%)
Disenrolled after being enrolled 12 months (implies they did not reapply or did reapply but were not deemed to be eligible anymore)	608 (5%)	479 (5%)
Disenrolled for another reason	11,385 (85%)	8,178 (92%)

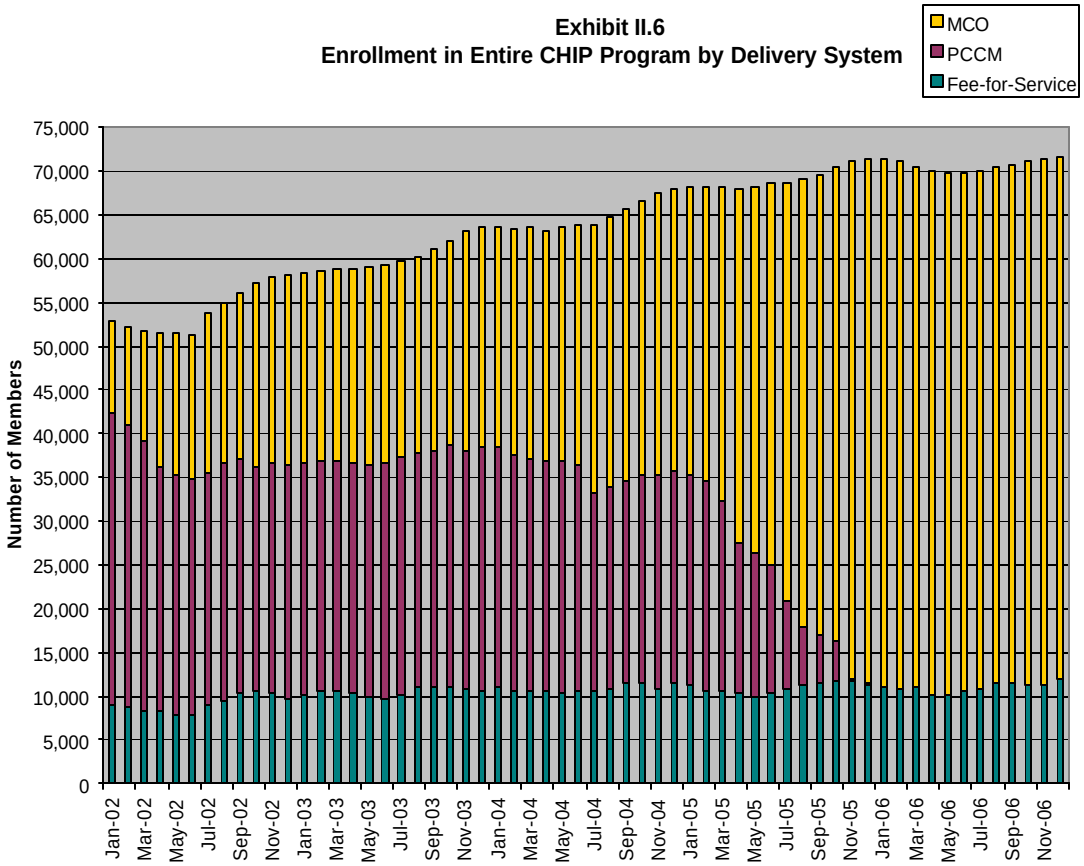
* Note that a child may have disenrolled in 2006 then reenrolled later in the year. In this case, the child is not in the disenrolled count if they were still enrolled at the end of 2006. Also, children that move from CHIP A to CHIP C or vice-versa are not counted as disenrolled. Likewise, movement between CHIP and Medicaid is not counted as disenrolled.

The data suggests that only a small portion of children are disenrolled due to turning 19 or because parents are not reapplying. The State does not track this data explicitly, nor the reason why children disenroll (e.g. parents get coverage at work, family moves out of state, etc.) with one exception. For children in CHIP Package C, members are disenrolled if premium payments are not made within 60 days of when they were due. However, members may reapply if their families get current with their premiums. Although the premium rates charged were doubled in February 2006, the CHIP Office reports that the rate of disenrollment due to non-payment of premiums was consistently 4%-5% of all enrollees in each month of 2006.

Enrollment by Service Delivery System

The Hoosier Healthwise Primary Care Case Management Program (PCCM) was eliminated as of December 2005 when all non-ABD (aged, blind and disabled) Hoosier Healthwise members were enrolled with a managed care organization (MCO). Like other enrollees in Hoosier Healthwise, CHIP members that were enrolled in the PCCM delivery system were transitioned to the Risk-Based Managed Care (RBMC) delivery system by enrolling with an MCO. Our review of each member's enrollment by delivery system shows that this was successful (see Exhibit II.6 on the next page).

Exhibit II.6
Enrollment in Entire CHIP Program by Delivery System



It should also be noted that the high turnover of members in CHIP results in an ever-evolving group of members that are temporarily enrolled in the Fee-for-Service (FFS) delivery system. Children and their families have 30 days after enrollment in CHIP/Hoosier Healthwise to select a primary medical provider (PMP) and MCO. Until the selection is made, the member remains in FFS, the non-managed care portion of Hoosier Healthwise. If the member does not select a PMP within 30 days, the State's policy is to automatically assign the child to a PMP in their geographic region that is contracted with an MCO. This policy is to promote the continued monitoring of the child's health care needs and to promote continuity among providers.

This policy implies that members would only be enrolled in the FFS delivery system for one month. B&A's review of member enrollment patterns, however, found that this was not always the case. Although there are some children in Hoosier Healthwise who may remain in FFS indefinitely due to the type of services they need (that is, their care is coordinated but outside of the MCO delivery system) or are not required to participate in managed care (e.g. wards of the state may join an MCO on a voluntary basis), CHIP members should all be enrolled in managed care. B&A also considered the fact that the data reporting system we retrieved data from may not be updated for those children most recently enrolled to reflect the shift from FFS to RBMC.

Therefore, B&A tracked all CHIP members that were enrolled in FFS for at least one month in the first six months of 2006 to determine the length of time they were actually enrolled in the FFS delivery system. We found that despite the State's policy to automatically assign members to a PMP if they do not choose on their own, there were 12% of children in CHIP Package A and 8% of children in CHIP Package C who have remained in FFS after their first month of enrollment. Some children (about 1,000 in CHIP A and 30 in CHIP C) have been in FFS for more than a year. Note that there are a few wards of the state who are also enrolled in CHIP. They have been excluded from this exhibit since they are not required to enroll in managed care.

Exhibit II.7
Children Who Have Remained In Fee-for-Service Beyond 30 Days

	CHIP Package A		CHIP Package C	
Number of Months in FFS through December 2006	**Total Ever Enrolled in FFS**	**Still Enrolled in FFS**	**Total Ever Enrolled in FFS**	**Still Enrolled in FFS**
1 month	763	0	897	0
2 months	1,619	27	1,829	21
3 months	1,779	51	2,003	99
4 months	1,877	90	1,502	101
5 months	2,769	122	1,057	99
6 months	2,201	130	896	124
7 to 12 months	3,516	462	1,636	285
13 to 18 months	710	250	78	15
19 to 24 months	415	256	23	9
25 or more months	621	582	10	4
All Members	**16,270**	**1,970**	**9,931**	**757**
Percent of Child Ever Enrolled in FFS that are Still Enrolled in FFS		**12%**		**8%**

It appears that there are opportunities for Indiana's CHIP to closely monitor the auto assignment process to assure that children become enrolled in managed care after one month if they have not selected a PMP on their own. One concern may be the availability of PMPs in certain rural counties. B&A's analysis found that the evidence of extended periods in the FFS system were not limited to rural areas of the state, however. About 25% of all children shown in the table above reside in either Marion County or Lake County.

Enrollment by MCO Within Managed Care

In CY 2006, CHIP members had the option to enroll with PMPs in one of five MCOs. The OMPP issued new MCO contracts effective January 1, 2007. This resulted in a change from five MCOs to three MCOs. However, where some of the MCOs in 2006 served specific geographic regions of the state, all three MCOs in 2007 are required to serve the entire state.

	MCO in 2006	MCO in 2007
Anthem		X
CareSource	X	
Harmony Health Plan	X	
Managed Health Services	X	X
MDWise	X	X
Molina	X	

Because three MCOs terminated at the end of 2006 and a new one was added in 2007, the distribution by MCO changed between 2006 and early 2007 (refer to Exhibits II.8 and II.9 on this page which show enrollment by MCO in 2006 and Exhibits II.10 and II.11 on the next page which show enrollment by MCO as of March 2007). The data shows that Anthem and MDWise picked up most of the members that were transferred from CareSource, Harmony Health Plan, and Molina. The proportion of members enrolled with Managed Health Services has remained relatively constant for both CHIP A and CHIP C. It should also be noted that the percentage of children enrolled in FFS has decreased slightly. This could be either due to lower new enrollees or an active effort to enroll members into managed care.

Exhibit II.8
Distribution of CHIP A Members by MCO
Average Across Calendar Year 2006

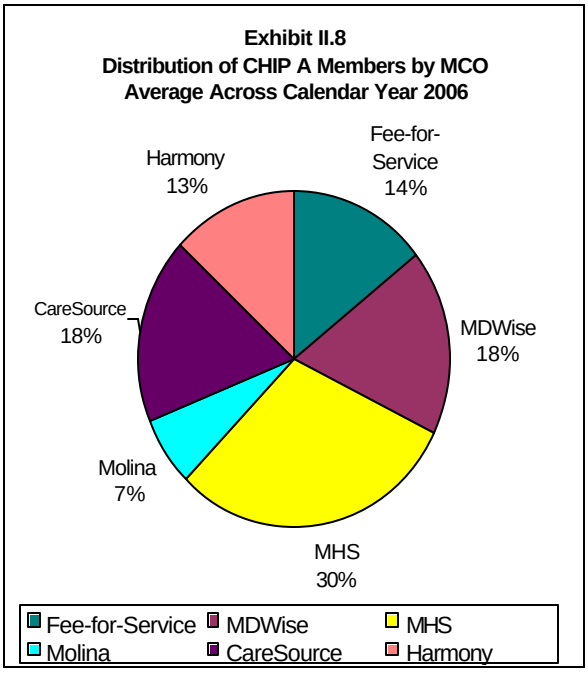
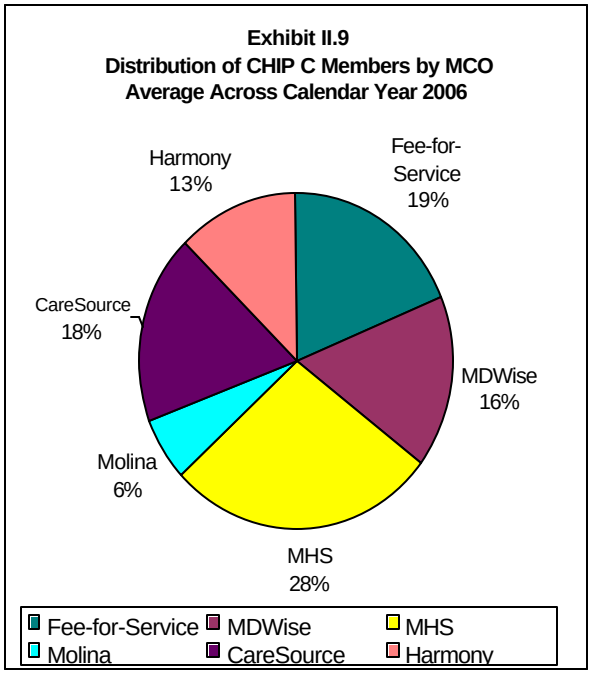
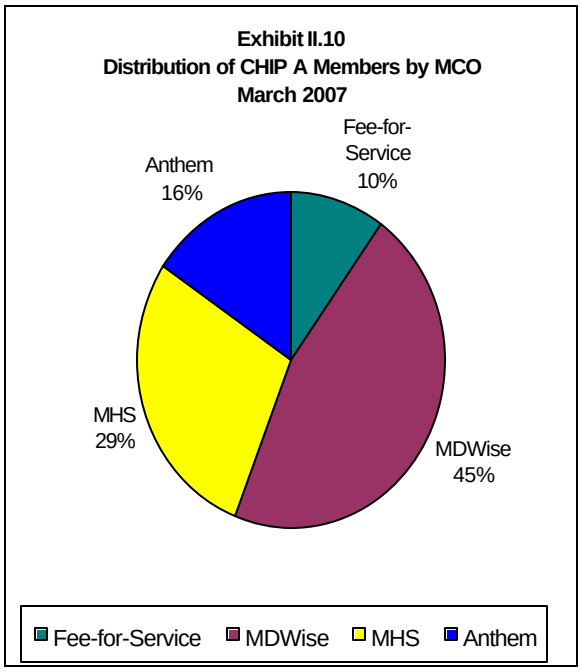
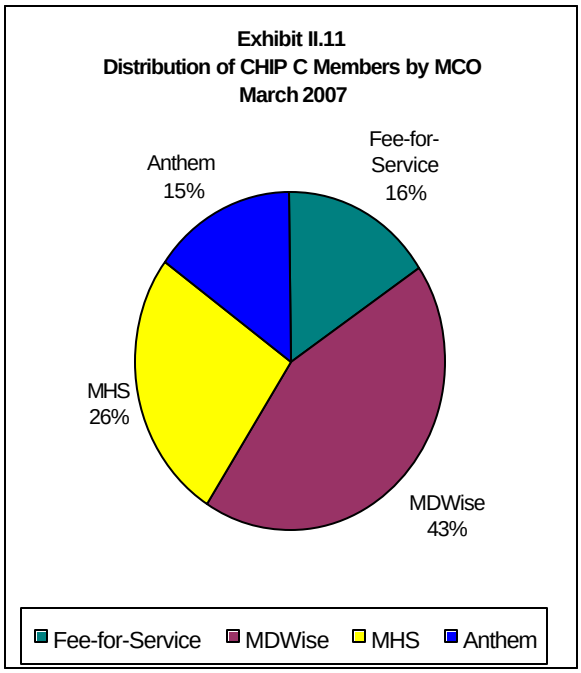


Exhibit II.9
Distribution of CHIP C Members by MCO
Average Across Calendar Year 2006

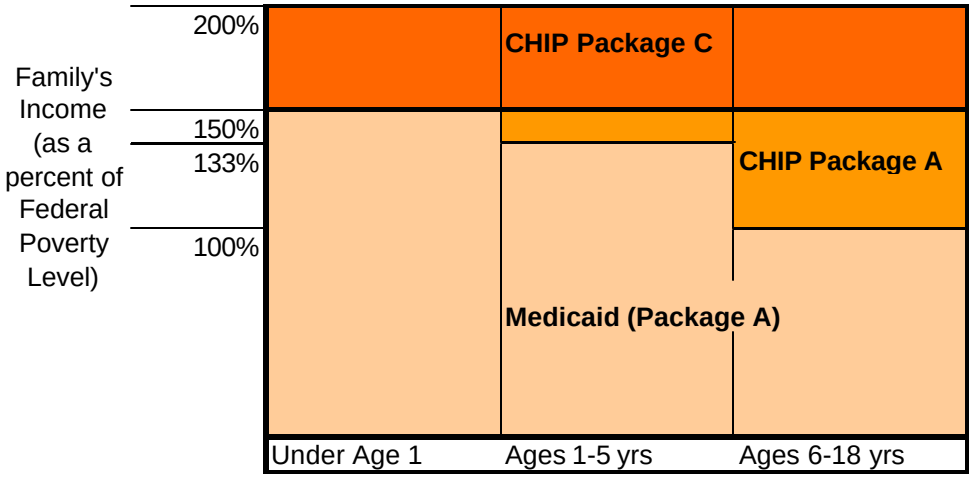




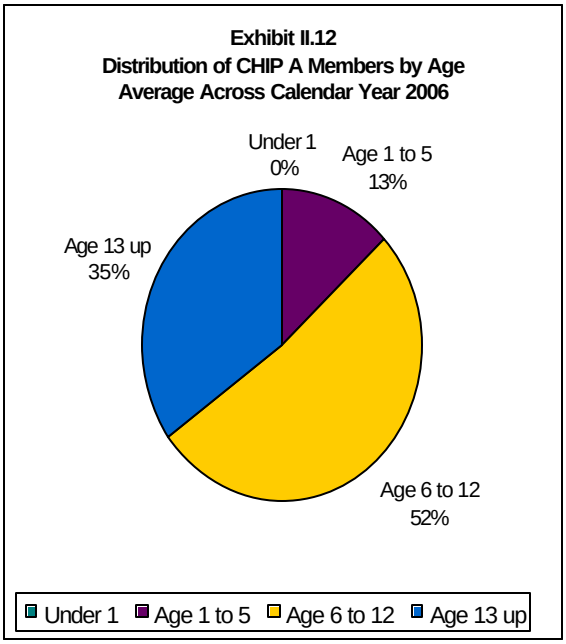


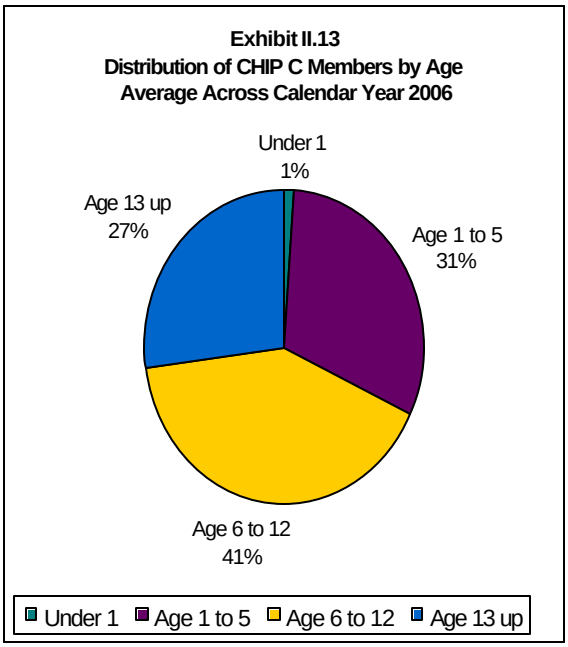
Enrollment by Age

Because younger children are eligible for Medicaid up to different family income levels, the distribution of children in Indiana's CHIP skews towards older children. This has been the case throughout the program's existence. The diagram below shows the eligibility levels for children at different ages.



In 2006, children ages 1 though 5 comprised 13% of the CHIP Package A population but 31% of CHIP Package C members. Children ages 6 through 12 comprised 52% and 41%, respectively. Teenagers (age 13-18) made up 35% of CHIP Package A and 27% of CHIP Package C. There are no infants in CHIP Package A since they are eligible for Medicaid and very few are in CHIP Package C (see Exhibits II.12 and II.13 on the next page).





Enrollment by Race

The distribution of CHIP enrollees by race in 2006 is not similar to the distribution of all children in Indiana by race. This finding is similar to the children in Medicaid, however. Based on state population estimates for 2005[1], the makeup of children in Indiana's CHIP compares to the overall child population in the State as follows:

Exhibit II.14
Comparison of CHIP Members by Race to Statewide Child Population

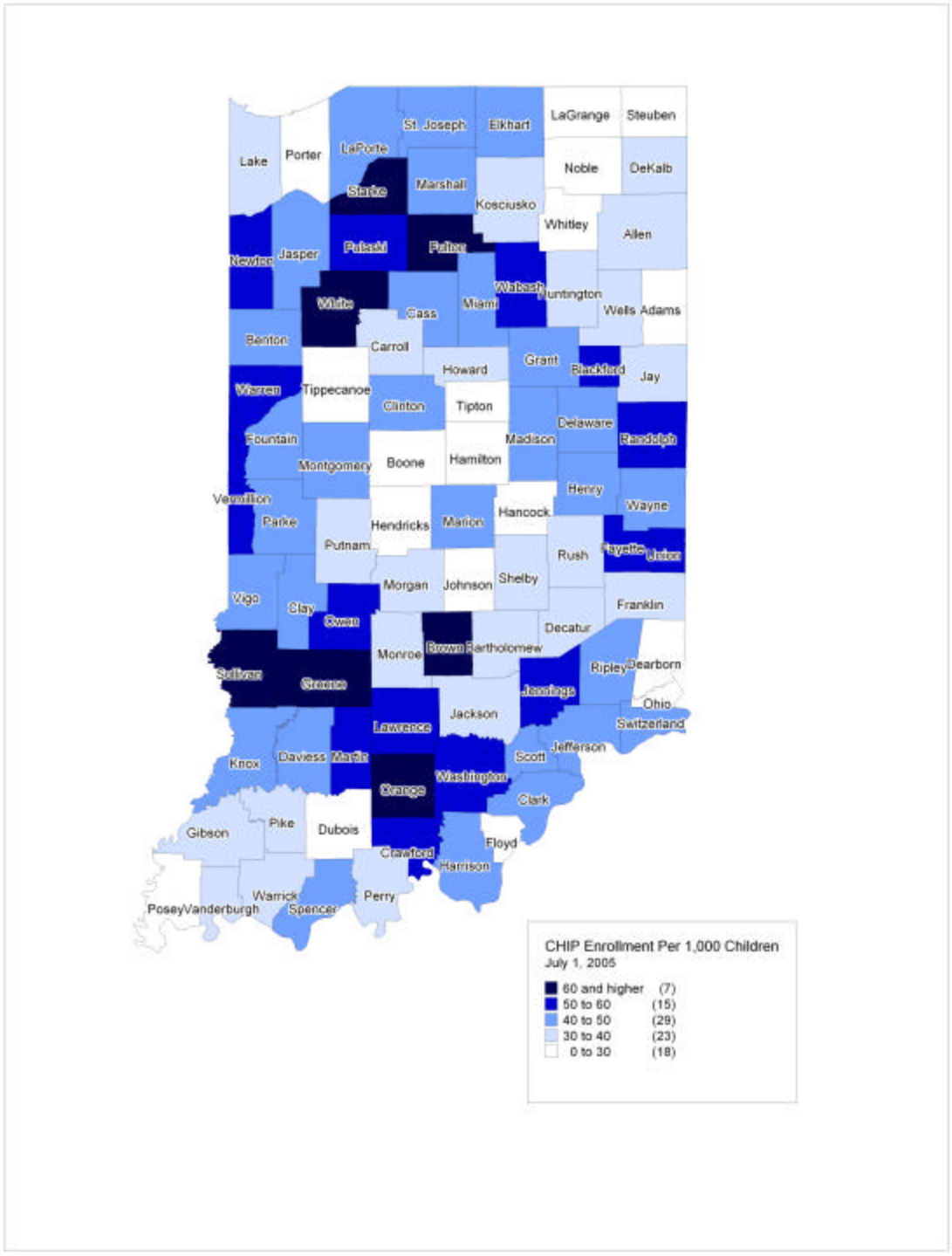
	Composition of CHIP Members	Composition of All Indiana Children
White	70.5%	85.5%
Black	16.3%	10.9%
Asian	0.6%	1.1%
Other Single Race	1.4%	0.3%
Two Races (includes Hispanic)	11.3%	2.2%

Enrollment by Region

Using the July 2005 Census estimate and July 2005 CHIP enrollment, B&A found no correlation of a high concentration of CHIP members in either urban or rural members, but rather, that high and low concentrations of CHIP members throughout the state were scattered. See the map in Exhibit II.15 on the next page.

[1] County Population Estimates by Age, Sex, Race and Hispanic Origin: April 1, 2000 to July 1, 2005, Population Estimates Program, Population Division, U.S. Census Bureau, Release Date: August 4, 2006

Exhibit II.15
CHIP Enrollment Per 1,000 Children By County



III. Access to Services

Chapter Highlights

- There are 34 counties in the state that do not have a pediatrician contracted with the Hoosier Healthwise program to serve Medicaid and CHIP children. Of these, however, all but two have family practitioners available to serve children. The remaining two counties, Ohio and Union, do have general practitioners that are willing to serve children.

- Of the remaining 58 counties that have pediatricians, eight counties have pediatricians that are not accepting new Hoosier Healthwise patients. All but one of these counties (Franklin) has more than sufficient capacity (also called panel size) among other types of doctors (family practitioners, general practitioners).

- Franklin and Tippecanoe County doctors across all specialties are not accepting new patients. There are four other counties that have 80% or more of their panel size full when measuring all doctors who will accept children as patients. They include Elkhart, Pike, Switzerland, and Union. This is down from 18 counties in 2005.

- Primary Medical Providers (PMPs) negotiate the number of Hoosier Healthwise patients they are willing to accept (panel size). The suggested panel size is 2,000 members, but doctors negotiate down from this number. Among the counties with full or mostly-full panels, the average number of Hoosier Healthwise patients that doctors in these counties will accept is between 108 and 283. Therefore, although some counties currently have panel size issues, there appears to be adequate opportunities for the State to negotiate with doctors in these counties to accept new patients.

- There does not appear to be a relationship between counties with full or near-full panel capacity and CHIP members' access to primary care. In four of the six counties, the percentage of CHIP members that saw their PMP in 2006 was above the statewide average. B&A also analyzed emergency room usage and found that none of the full/near-full panel counties had a disproportionate volume of ER usage among CHIP members.

- B&A measured the rate at which CHIP members saw their own PMP or any type of primary care service. For members enrolled at least nine months in 2006, 72% of CHIP A members saw their own PMP, while 81% saw either a PMP, a specialist, or had a clinic visit. Among CHIP C members, 83% saw their own PMP while 90% had some type of primary care visit.

Introduction

This chapter analyzes potential issues related to CHIP members' ability to access primary care services. In the Risk-Based Managed Care (RBMC) delivery system, CHIP members select a primary medical provider (PMP). If a member does not select a PMP, the State selects one for them based on proximity to their home and the willingness of providers in their area to accept new patients.

PMPs contract with managed care organizations (MCOs) directly. Therefore, a member is assigned to the MCO which their PMP contracts with. As of January 2007, PMPs may contract with more than one MCO, offering members additional choice not only on which PMP to select but also which MCO to select.

Because the CHIP members share the same delivery system as other children in traditional Medicaid, access to physicians must be evaluated for all children in the Hoosier Healthwise program. Burns & Associates (B&A) explored the following areas to evaluate potential access issues:

(1) B&A's own examination of members' access to pediatricians.

(2) The OMPP's monitoring of PMP panel size, that is, the percentage of slots available for members to enroll with a PMP in each county. Although not limited to pediatricians specifically, the OMPP does evaluate panel size only for those providers willing to accept children as patients (e.g. family practitioners, general practitioners).

(3) Evaluating whether or not counties with potential panel size issues may have CHIP members with limited usage of PMP services.

(4) Evaluating if counties with potential panel size issues have members that use the hospital emergency room at a higher rate because their access to primary care may be limited.

(5) The potential for additional capacity among existing providers to accept new patients.

Availability of Pediatricians

There are 670 county pediatricians contracted with the Hoosier Healthwise program. The term "county pediatricians" is used because some pediatricians have offered to serve children in more than one county. In all of Hoosier Healthwise, 223,919 children (March 2007 figure) have enrolled with pediatricians (42% of all children enrolled). These same percentages held true for CHIP A and CHIP C specifically.

Statewide, 48% of the panel slots for pediatricians are full. At the county level, there is some limited access to pediatricians. In 34 counties, there is no pediatrician that has contracted with Hoosier Healthwise. Among these, all but two counties (Ohio and

Union) do have family practitioners available to see CHIP members. In Ohio and Union counties, although there are no family practitioners available, there are general practitioners that will accept children as patients. The map on the following page shows the counties with no pediatricians.

Among the 58 counties that do have pediatricians enrolled with Hoosier Healthwise, in nine of these counties the doctors' panel size is full (Clinton, Dubois, Franklin, Fulton, Harrison, Hendricks, Marshall, Shelby, and Wayne). In every county but Franklin, however, there is sufficient panel size among other physician specialties (e.g. family practitioner, general practitioner) willing to accept children as patients.

Franklin County is the exception. This county is determined by OMPP to have a panel size above 100% (i.e. doctors have taken all Hoosier Healthwise patients they are willing to accept). The other county in this situation is Tippecanoe County, which has three pediatricians but they, like other PMPs, have full panels. Four other counties are deemed by OMPP to be "near full panels", meaning that they are above 80% capacity. These counties are Elkhart, Pike, Switzerland, and Union. The map on page III-5 shows the counties with full pediatrician panels and full or near-full total PMP panels.

It should also be noted that the six counties which are deemed full or near-full panels may still have room to add panel slots. PMPs negotiate with the State the number of Hoosier Healthwise patients they are willing to accept. The suggested panel size is 2,000 members, but doctors negotiate down from this number. Among the counties with full or mostly-full panels, the average number of Hoosier Healthwise patients that doctors in these counties will accept is between 108 and 283. Therefore, although some counties currently have panel size issues, there appears to be adequate opportunities for the State to negotiate with doctors in these counties to accept new patients.

Exhibit III.1
Availability of Pediatricians and Family Practitioners in the County

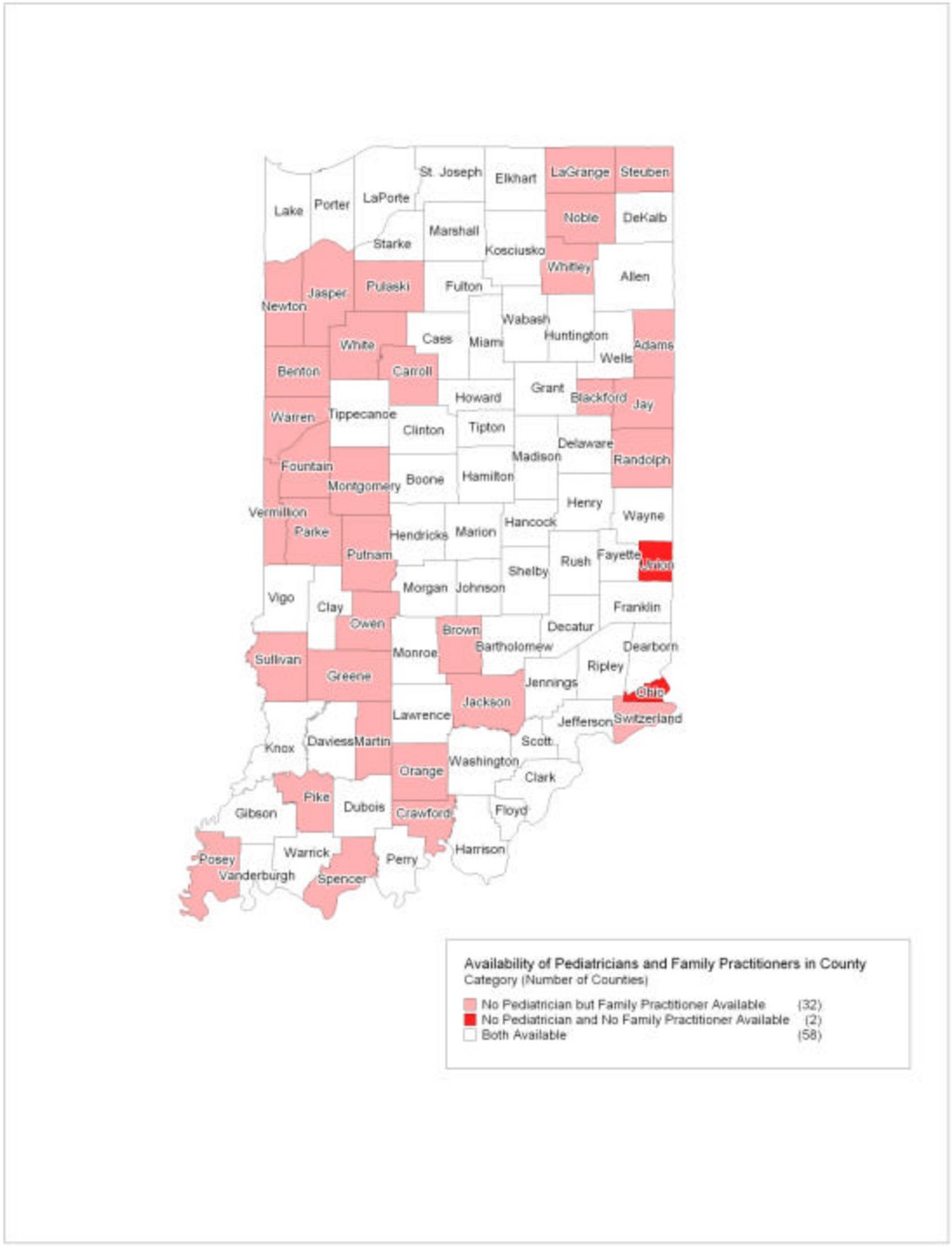
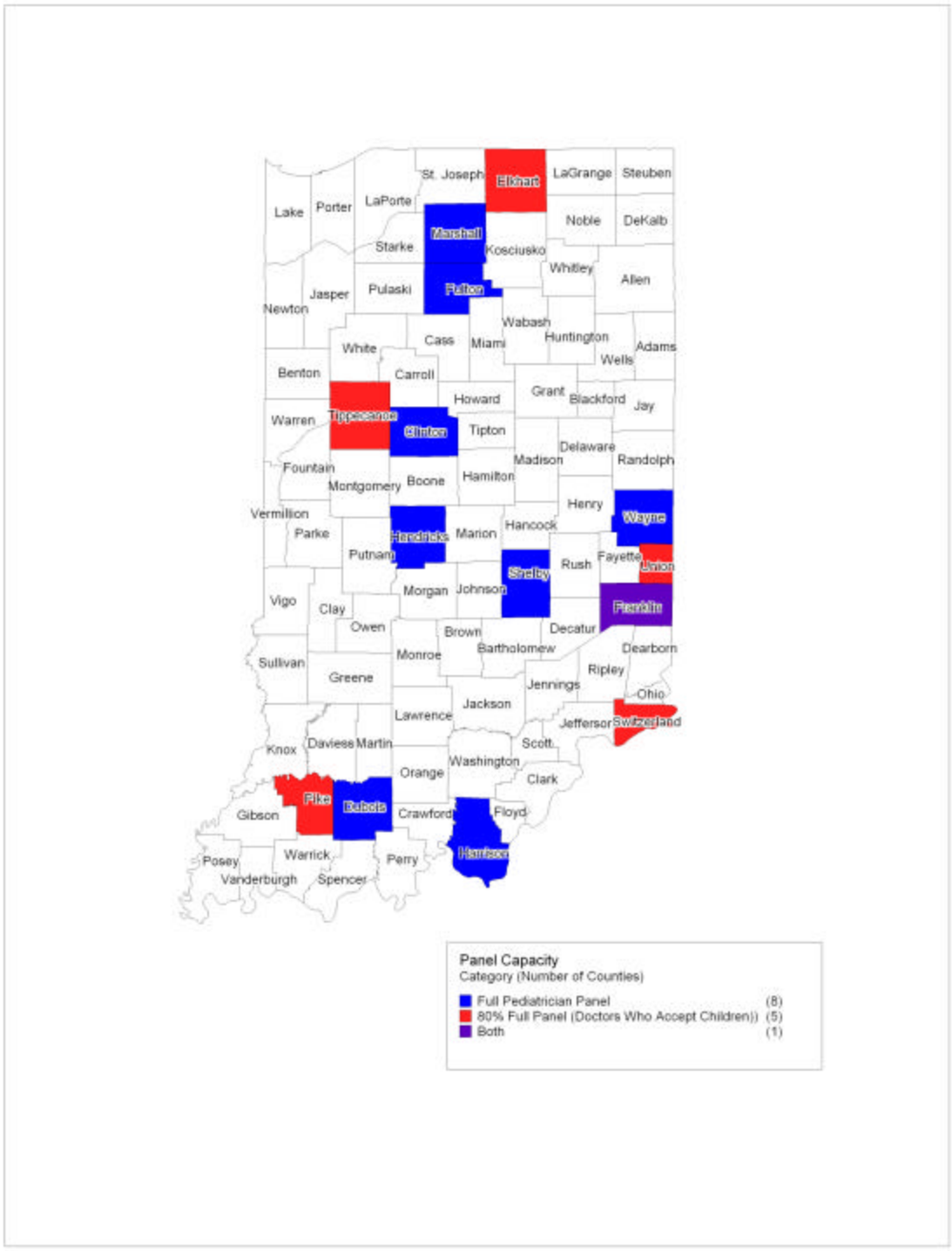


Exhibit III.2
Panel Capacity for PMPs Who Accept Children



Evaluating the Potential Impact of Panel Size Issues on Access

B&A examined utilization of CHIP members in those counties with potential panel size issues to determine if the potential panel size problem is having an impact on members' access to primary care services. Our evaluation found that there was little to no correlation showing limited access to/usage of services for members in the counties with potential panel size issues.

To conduct our examination, we identified separately utilization aspects for all members and identified counties with:

(1) The highest percentage of members using PMP services

(2) The highest percentage of members using either PMP, specialist, or clinic services

(3) The highest percentage of members using hospital ER services (assuming the ER is where members will seek services in the absence of PMPs)

The members included in each study are those that were enrolled in CHIP or some portion of Hoosier Healthwise for at least nine months of 2006. Maps illustrating member usage by county appear at the end of this section.

The rates of use of each service mentioned above were compared to the six counties with full or near-full panel sizes (see Exhibit III.3 on next page). One of the near-full panel counties (Pike) was also among the counties with the highest CHIP member usage of their assigned PMP. Three others did not have the highest percentage of assigned PMP usage but were above the statewide average (Elkhart, Switzerland, Union).

None of the full or near-full panel counties were also counties with the highest ER usage among CHIP members in 2006. The high usage of the members' assigned PMP and the lower usage of ER services implies that the potential panel size issues are not impacting CHIP members' access to primary care services.

The remaining two counties with a potential panel size issue (Franklin and Tippecanoe) were counties that did not have the highest usage of PMP services among members but they were also not counties with the lowest usage. This analysis provides evidence that potential panel size issues in selected counties do not appear to be impacting CHIP members' access to primary care services.

Exhibit III.3
Correlation Analysis Across Access and Utilization Measures

County	Exhibit III.2 80% or Fuller Panel Size	Exhibit III.4 Counties with Highest Assigned PMP Access (85% of Members or More)	Exhibit III.5 Counties with Highest PMP, Specialist or Clinic Access (90% of Members or More)	Exhibit III.6 Counties with Highest ER Access (50% of Members or More)
		Positive	*Positive*	*Negative*
Blackford				X
Clark		X		
Daviess				X
Delaware		X	X	
Elkhart*	X			
Fayette				X
Floyd		X	X	
Franklin	X			
Fulton		X	X	
Gibson			X	
Harrison		X	X	
Huntington		X	X	
Jasper		X	X	
Knox				X
Ohio		X		
Orange		X	X	
Perry			X	X
Pike	X	X	X	
Posey		X	X	
Pulaski			X	
Scott				X
Shelby		X	X	X
Starke		X	X	
Switzerland*	X			
Tippecanoe	X			
Union*	X		X	
Vanderburgh			X	
Vermillion				X
Warrick		X	X	
Wayne				X
Wells		X	X	
White		X	X	
Whitney		X		

* Although these counties do not have highest Assigned PMP usage, they are above the statewide average.

No 80% or fuller panel size counties (Group A) are among counties with highest ER usage (Group D).

Exhibit III.4
Percent of Members Who Visited Their Assigned PMP

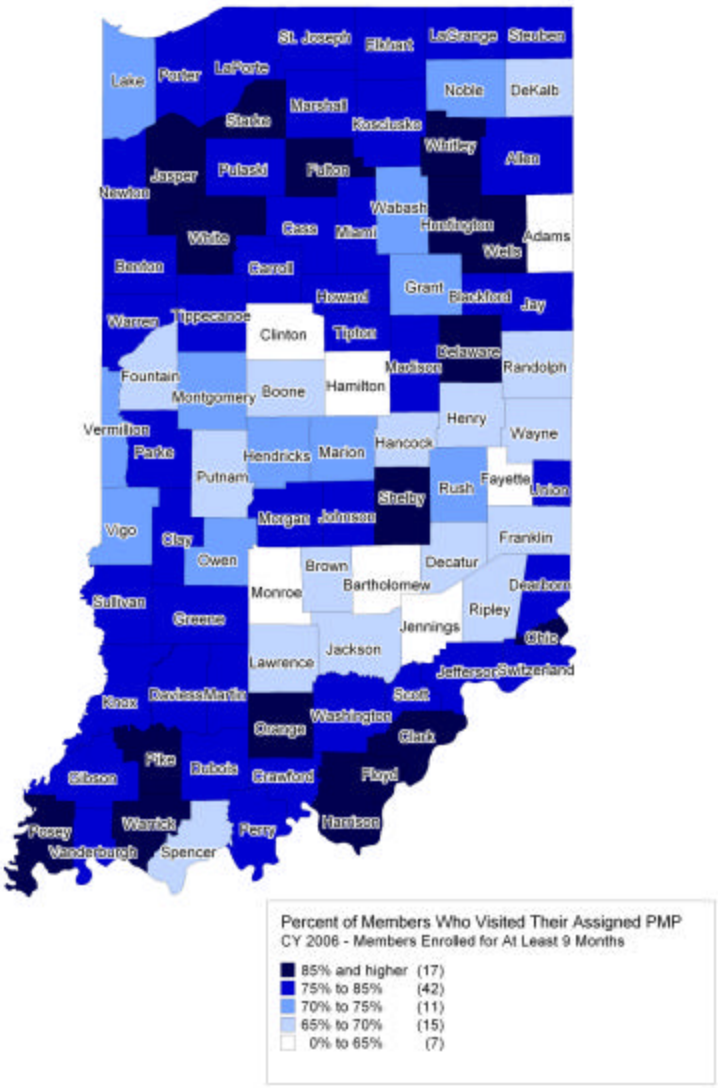


Exhibit III.5
Percent of Members Who Visited a PMP, Specialist or Clinic

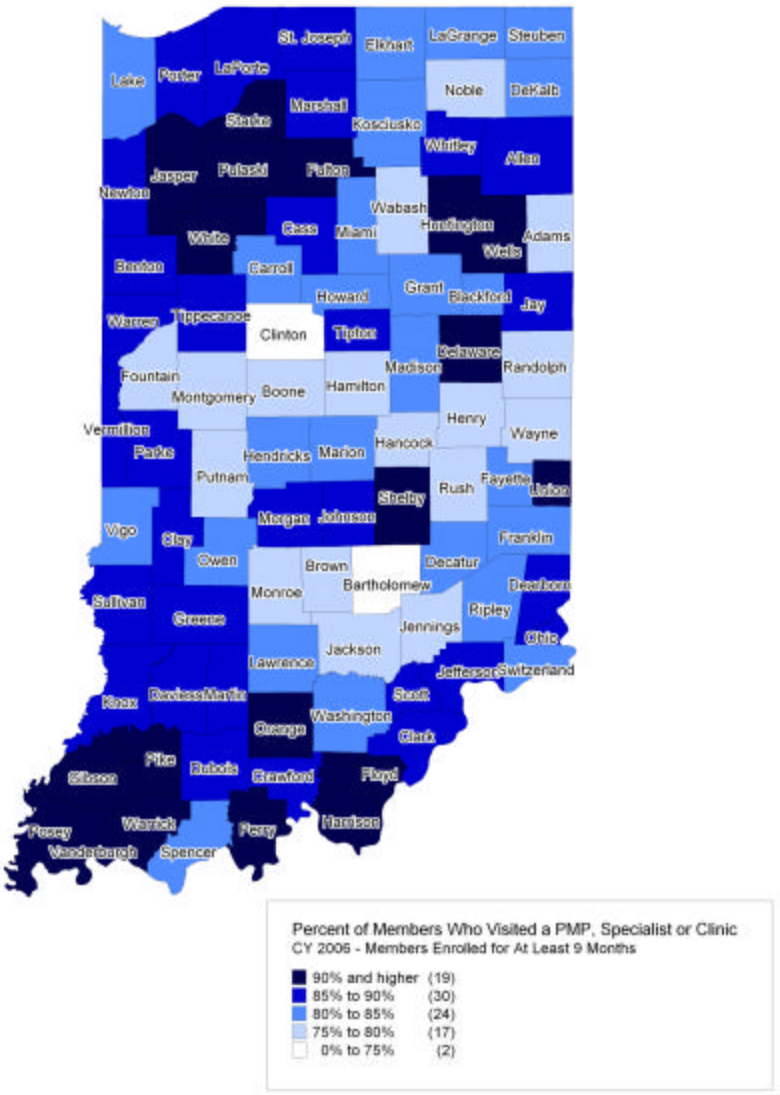
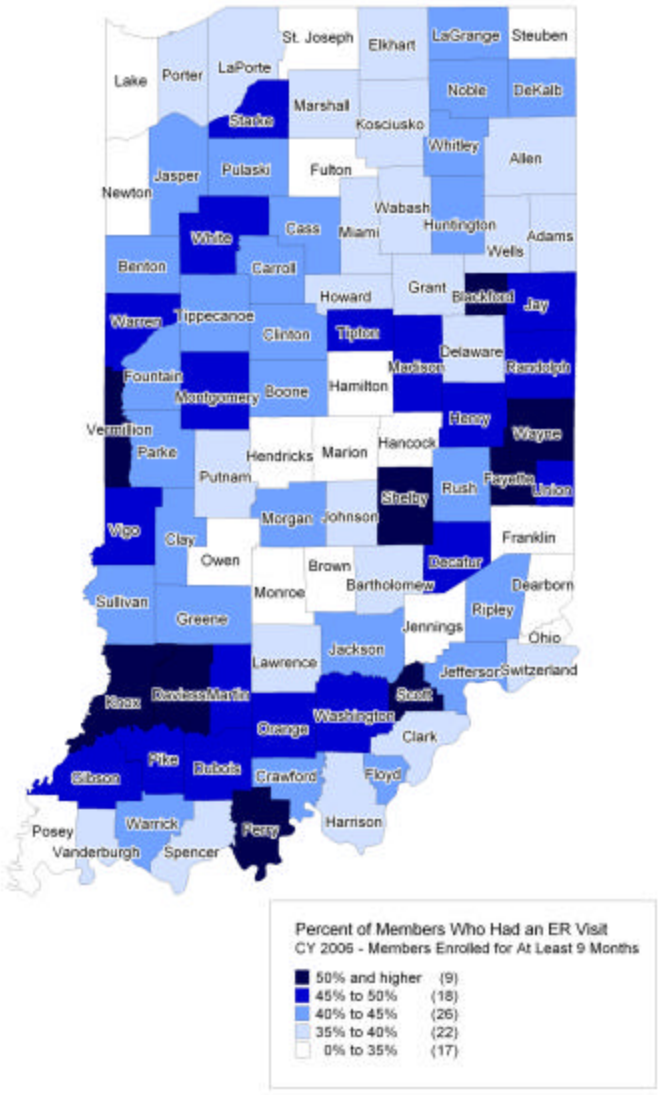


Exhibit III.6
Percent of Members Who Had an Emergency Room Visit



IV. Utilization of Services in Indiana's CHIP

Chapter Highlights

- CHIP A and CHIP C members who were enrolled for at least nine months in the year were studied to determine if they had used 11 different types of services available to them. In all 11 cases, in both CY 2005 and CY 2006, there were a higher percentage of CHIP C children utilizing each service than the percentage of CHIP A children. Significant differences were found in the percentage of children that see their Primary Medical Provider (PMP), those that saw another PMP not assigned to them, those that had a prescription, and those that had an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) examination.

- Across all 11 service types studied, the percentage of children receiving each service was slightly higher in CY 2005 than what was reported in CY 2006 (when children enrolled at least nine months in each year were studied). This was true when comparing CHIP C and CHIP A separately across the two years. Most differences in utilization were not significant, the largest being for the percentage of children who saw their PMP or who had a prescription. Some of the lower utilization in CY 2006 may be due to the fact that not all of the service claims have been remitted by providers yet.

- The same study of children enrolled at least nine months was conducted to compare CHIP members to children in traditional Medicaid. In 10 out of 11 services studied, a higher percentage of CHIP children used services than Medicaid children. The one service where Medicaid children had higher utilization was inpatient hospital, but this is because the vast majority of infants are in Medicaid and their stay when they are born is counted as an inpatient stay.

- There were significant differences between the percentage of CHIP children and Medicaid children who saw their assigned PMP (72% of CHIP A children, 83% of CHIP C children, 60% of Medicaid children in 2006) or who had a preventive dental visit (68% of CHIP A children, 71% of CHIP C children, 48% of Medicaid children). The utilization of EPSDT services was similar between CHIP and Medicaid children.

- The percentage of children utilizing each service was also compared by age group to the overall child averages. Age groups studied were age 1-5, 6-12, 13-18 female and 13-18 male. Infants were excluded since there are so few in CHIP. Relatively speaking, the percentage of children utilizing each service was similar across age groups, with some anticipated differences in some areas. For example, more children age 1-5 had an EPSDT test than other children. Likewise, this age group had fewer dental visits than the others. Teenagers were more likely to have visited a specialist. Female teens were

more likely to have had an outpatient hospital service (excluding emergency room) and to have visited a clinic.

- Similar to the comparison by age group, the percentage of children utilizing services was compared at the health plan level. Each of the five managed care organizations (MCOs) under contract in CY 2006 was analyzed: MHS, MDWise, Harmony, CareSource, and Molina. One common trend found was that children enrolled with CareSource were less likely to use most services than their counterparts in other MCOs, with the exception of services in the ER, getting a prescription, and having a preventive dental visit. With the exception of CareSource, the other four MCOs had similar results on the percentage of children who saw their PMP. For CHIP A members, these percentages ranged from 76% to 83%. For CHIP C members, the percentages ranged from 86% to 90% in CY 2006.

- Children who were new enrollees into CHIP were also studied to determine if a medical event was what prompted their enrollment. B&A's analysis found no evidence that this was occurring. All new enrollees in CHIP A and CHIP C were examined to find all services they received in the first three months of enrollment. Their utilization was much lower than their counterparts who had been enrolled at least nine months of the year. As was found in the other analyses, however, the newly-enrolled CHIP C members were more likely to have used all types of service than the newly-enrolled CHIP A members.

- There appears to be opportunities to improve the usage of services among CHIP's youngest members aged 1-5. In CY 2006, 78% of CHIP A members enrolled at least nine months saw their PMP. For CHIP C, it was 83%. Also, the evidence of an EPSDT visit in CHIP A and CHIP C was 58% and 64%, respectively. Among older CHIP members (ages 6 and up), preventive dental visit rates have improved over the years, but were slightly above 70% for CHIP A members and slightly above 80% for CHIP C members.

- The State is encouraged to work with the MCOs to determine the rate at which CHIP members are seeing PMPs that are not assigned to them. In 2006, 27% of CHIP A members and 37% of CHIP C members saw a PMP they were not assigned to. B&A noticed that most of the visits to an "unassigned" PMP were when members first enrolled and had yet been assigned to a PMP. However, 11% of all claims submitted by MCOs for PMP visits were when members saw a PMP they were not assigned to. Indiana's CHIP may want to study whether or not this is simply a data reporting issue (e.g. the member's assigned PMP is not listed on the claim visit) or if there is an underlying access issue. To promote the continuity of care, members should see their assigned PMP for all non-specialized care.

Introduction

To identify trends in the usage of services among CHIP members, Burns & Associates (B&A) studied usage rates across a number of dimensions, including:

(1) Usage by CHIP A members as compared to CHIP C members
(2) Usage by CHIP members as compared to children in traditional Medicaid
(3) Usage by age group within both CHIP A and CHIP C
(4) Usage by members enrolled with different MCOs

Historically, CHIP C members have been higher utilizers than other children in Hoosier Healthwise. It is assumed that since parents are paying premiums in this program, they are taking a more active approach to their child's care. We found this trend continued in CY 2005 and CY 2006 when studying those enrolled for most of the year.

Due to the nature of the service, there will be anticipated differences in the utilization of some services by age group. B&A reviewed the data to determine if these assumptions held true as expected.

The way that different MCOs manage the care of their members may be signaled through utilization patterns. For example, some MCOs may send reminders to parents to schedule check-ups for their children annually while others may not. Some MCOs may strongly discourage members from going to the emergency room for non-emergent care. B&A analyzed usage of members within each MCO to determine if distinct differences in care management could be found.

Methodology

To conduct our study, we identified all members enrolled in CHIP for at least some point in CY 2005 and separately for at least some point in CY 2006. Children were further separated between CHIP A and CHIP C. Although members could have been enrolled in either portion of CHIP, they were categorized into either CHIP A or CHIP C, depending upon where they were enrolled at the end of each calendar year (or where they were before disenrolling completely). Some members may have been enrolled in the Fee For Service portion of Hoosier Healthwise on a temporary basis before joining an MCO.

Service usage was then studied for two sets of children in CHIP A and CHIP C:

(1) Those enrolled at least nine months of the calendar year
(2) Those newly-enrolled and the services they used in their first three months of enrollment. Enrollment data going back to 2002 was used to assist us in defining which members were new to CHIP.

Different groups of children were then identified and categorized into one of eight unique groups.

CY 2005

Enrolled at least 9 months

1. CHIP A
2. CHIP C

Newly enrolled

3. CHIP A
4. CHIP C

CY 2006

Enrolled at least 9 months

5. CHIP A
6. CHIP C

Newly enrolled

7. CHIP A
8. CHIP C

It should be noted that a child may fit the 9-month criteria in one year but not another year. Also, even if a child fit the 9-month criteria both years, they may be categorized as CHIP A in one year and CHIP C in the other, depending upon where they were enrolled at the end of the calendar year.

Once the children were assigned to one of the eight groups, their enrollment in an MCO was identified. Our focus for this report was the child's MCO enrollment in CY 2006, so all results by MCO are for children in groups 5-8 above.

Services Studied

For each of the groups of children identified in the previous section, B&A reviewed the data submitted by MCOs to the State to determine if each child had utilized one of 11 services. All but one of the services we reviewed (dental) is the responsibility of the MCOs to provide to its members. There are some exceptions with respect to a subset within a service, such as certain behavioral health drugs or inpatient psychiatric care within the covered general acute hospital care service. To account for these exceptions, B&A also included claims for services in our 11 groups that were paid outside of the usual monthly capitation payment made to the MCO.

The services we analyzed to determine member usage include the following:

Visited their assigned PMP	Each member in managed care is assigned a primary medical provider. B&A analyzed to see if the member saw this provider (or a member of the provider's group practice) at some point in the year.
Visited another PMP	Members may have seen a PMP before enrolling in managed care, or may have seen a PMP other than the one assigned to them or one not in their doctor's group practice. The PMP identified on the claim along with his/her group practice ID was matched to the member's assigned PMP. When there was no match, the visit was classified in this category.
Visited a specialist	Includes services not performed by a physician who is not the member's PMP, not considered a PMP using OMPP's definition of a PMP, and is not an ER doctor.
Visited a clinic	Members may receive services in a clinic in addition to or in lieu of their PMP's office. However, if the member's PMP has their primary location at a clinic, we put these PMP visits in the Assigned PMP category. Also included in this category are hospital-based clinics.

Visited a PMP, specialist or clinic	A larger categorization if the member had used any one of the four services mentioned above.
Had an EPSDT service	An EPSDT service is a specific type of visit in which a screening is done to test certain conditions or diagnoses. The federal government requires each Medicaid agency to report annually on the number of EPSDT services provided to children covered under its program. Hoosier Healthwise separately identifies EPSDT visits, so a child who saw their PMP and received an EPSDT visit would be recorded here and not in the Assigned PMP category. Examples of EPSDT services include immunizations, hearing test, vision test, lead screening, and sickle cell anemia test.
Had an inpatient hospital stay	Any overnight stay in the hospital.
Had a service in the ER	Any outpatient service billed by a hospital with an emergency room revenue code. The service may be deemed emergent or non-emergent.
Had a non-ER outpatient hospital service	Other hospital services outside the ER and clinic performed as an outpatient.
Had a prescription filled	These are identified by specific claims submitted by MCOs or pharmacies.
Had a preventive dental appointment	Although dental screenings may be included as an EPSDT service, dentists submit separate claims for services they perform for CHIP members. The usage measured here reflects services specifically billed by dentists.

Findings

The eight exhibits shown on the following pages summarize our findings of service usage across the dimensions studied. The matrix below can be used as a reference to understand the differences between each exhibit.

	Enrollees		Program			Categories	
	9-month minimum	New	CHIP A and C	CHIP A only	CHIP C only	By Age Group	By MCO
Exhibit 1	X		X				
Exhibit 2	X			X		X	
Exhibit 3	X				X	X	
Exhibit 4	X			X			X
Exhibit 5	X				X		X
Exhibit 6		X	X				
Exhibit 7		X		X		X	
Exhibit 8		X			X	X	

A description of the findings is discussed before each exhibit as it is presented below.

Exhibit 1: Utilization Statistics in CHIP A and CHIP C for CY 2005 and CY 2006

In this exhibit, CHIP members who were enrolled for at least nine months in CY 2005 and CY 2006 were studied to determine if there were different usage patterns between CHIP A and CHIP C members or if usage differed between 2005 and 2006.

The sample of children included in the study is shown along with the enrollment at the end of each year.

	2005 Members in Exhibit	December 2005 Enrollment	2006 Members in Exhibit	December 2006 Enrollment
CHIP A	49,800	52,734	50,688	53,162
CHIP C	17,883	18,602	17,515	18,343

Key findings:

(1) A higher percentage of CHIP C members used each of the 11 services studied than CHIP A members in both CY 2005 and CY 2006.

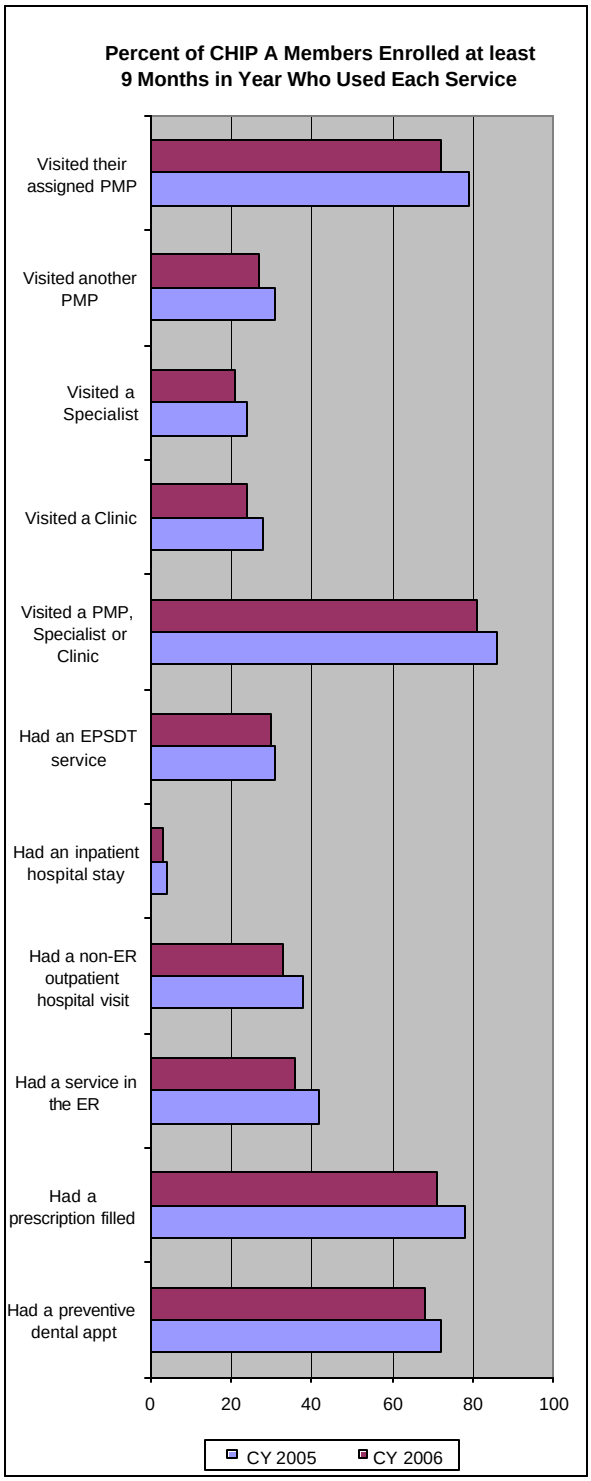
(2) For both CHIP A and CHIP C, there was slightly higher usage among members in CY 2005 than in CY 2006. This, however, may be the result of some service claims yet to be submitted to the State.

(3) CHIP C members are high utilizers of PMP visits (83% saw their PMP in 2006), pharmacy scripts (80% had a prescription), and preventive dental visits (71% had a visit in 2006). Children in CHIP A had slightly lower utilization (72% for PMP visits, 71% for prescriptions, and 68% for preventive dental visits).

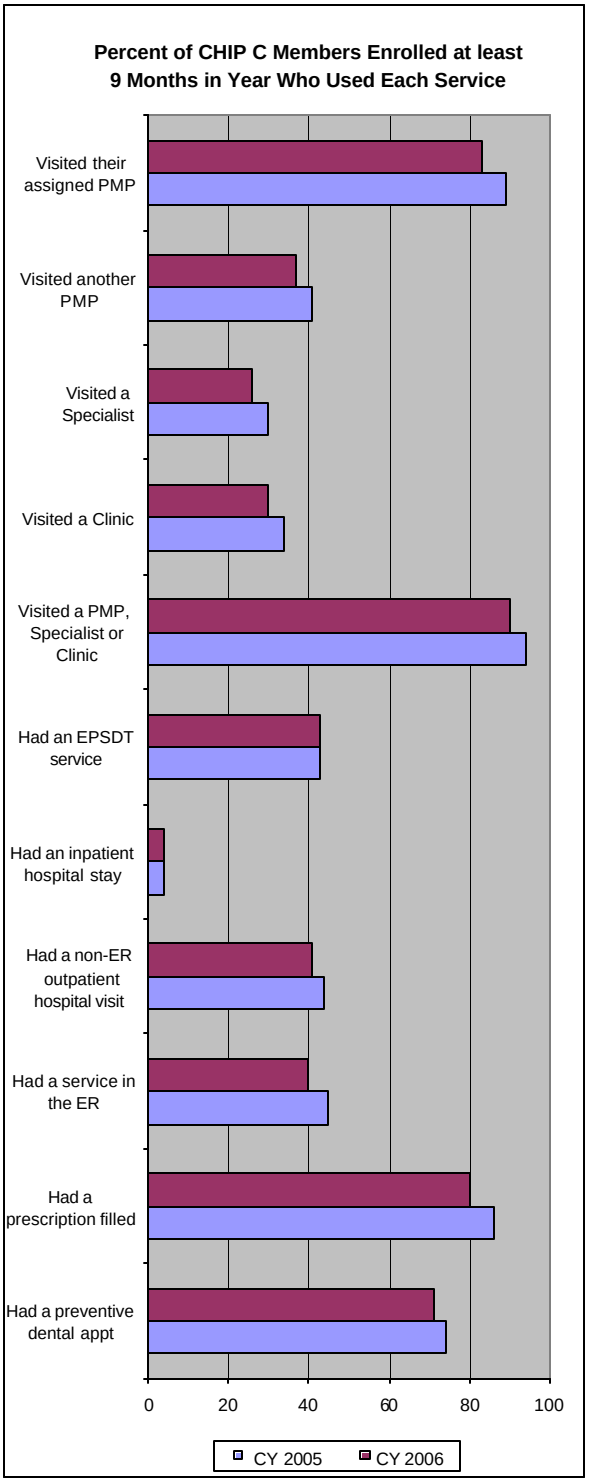
(4) The CHIP Office should work with the MCOs to improve the rate of EPSDT visits. It is unknown at this time whether the low usage reported is due to actual low utilization or improper recording of an EPSDT visit. In 2006, only 43% of CHIP C members studied had an EPSDT visit; for CHIP A, it was 30%.

(5) The rate of usage of the hospital emergency room should also be studied to determine whether or not the usage is actually emergent or if the service could be delivered in a less intensive setting. In 2006, 40% of CHIP C members had a service in the ER; for CHIP A, it was 36%. B&A observed that many of the ER visits did not have one of the five ER procedure codes that normally are listed on an ER claim (no procedure code was listed). The CHIP Office should explore the specific types of services being submitted as ER services.

Exhibit IV.1
Utilization Statistics in CHIP A and CHIP C
Statewide Totals



2005 sample= 49,800; 2006 sample= 50,688



2005 sample= 17,883; 2006 sample= 17,515

Exhibit 2: Utilization Statistics for CHIP Package A Children by Age Group in 2006
Exhibit 3: Utilization Statistics for CHIP Package C Children by Age Group in 2006

Exhibits 2 and 3 compare the rate of service usage of the same children shown in Exhibit 1 but divided into four age groups. These are ages 1-5, 6-12, 13-18 female, and 13-18 male. Children under age 1 are not shown in the analysis since there are only a few enrolled in all of CHIP.

The sample of children included in the exhibits is shown below.

	Age 1-5	Age 6-12	Age 13-18 Female	Age 13-18 Male
CHIP A	6,538 (13%)	26,259 (52%)	8,908 (18%)	8,981 (18%)
CHIP C	5,415 (31%)	7,146 (41%)	2,395 (14%)	2,507 (14%)

The findings for Exhibits 2 and 3 are shown together since the trends are similar by age group in CHIP A and CHIP C.

Key findings:

(1) Although CHIP members saw their PMP more often than CHIP A members, the percentage of children who visited their assigned PMP was similar across age groups within CHIP A and CHIP C.

(2) Likewise, the percentage of children who had a prescription filled was within five percentage points of the statewide average for each age group in CHIP A and CHIP C.

(3) Children ages 1-5 were less likely to have a preventive dental visit (around 40% in CHIP A and CHIP C), whereas 70% of other children in CHIP A and 80% of other children in CHIP C had a preventive dental visit.

(4) As reported previously, the rate of EPSDT services could be improved in both CHIP programs. However, the rate was higher as expected for the youngest age group, with 58% of CHIP A children age 1-5 having an EPDST visit (versus 30% for all age groups) and 64% of CHIP C children age 1-5 having an EPDST visit (versus 43% for all age groups).

(5) Emergency room usage, reported as potentially being too high in Exhibit 1, was relatively similar across age groups in both CHIP A and CHIP C.

(6) Teenagers in both CHIP A and CHIP C were more likely to have an outpatient hospital service, a clinic visit, and to have seen a specialist than younger CHIP members.

Exhibit IV.2
Utilization Statistics for CHIP Package A Children in 2006
By Age Group

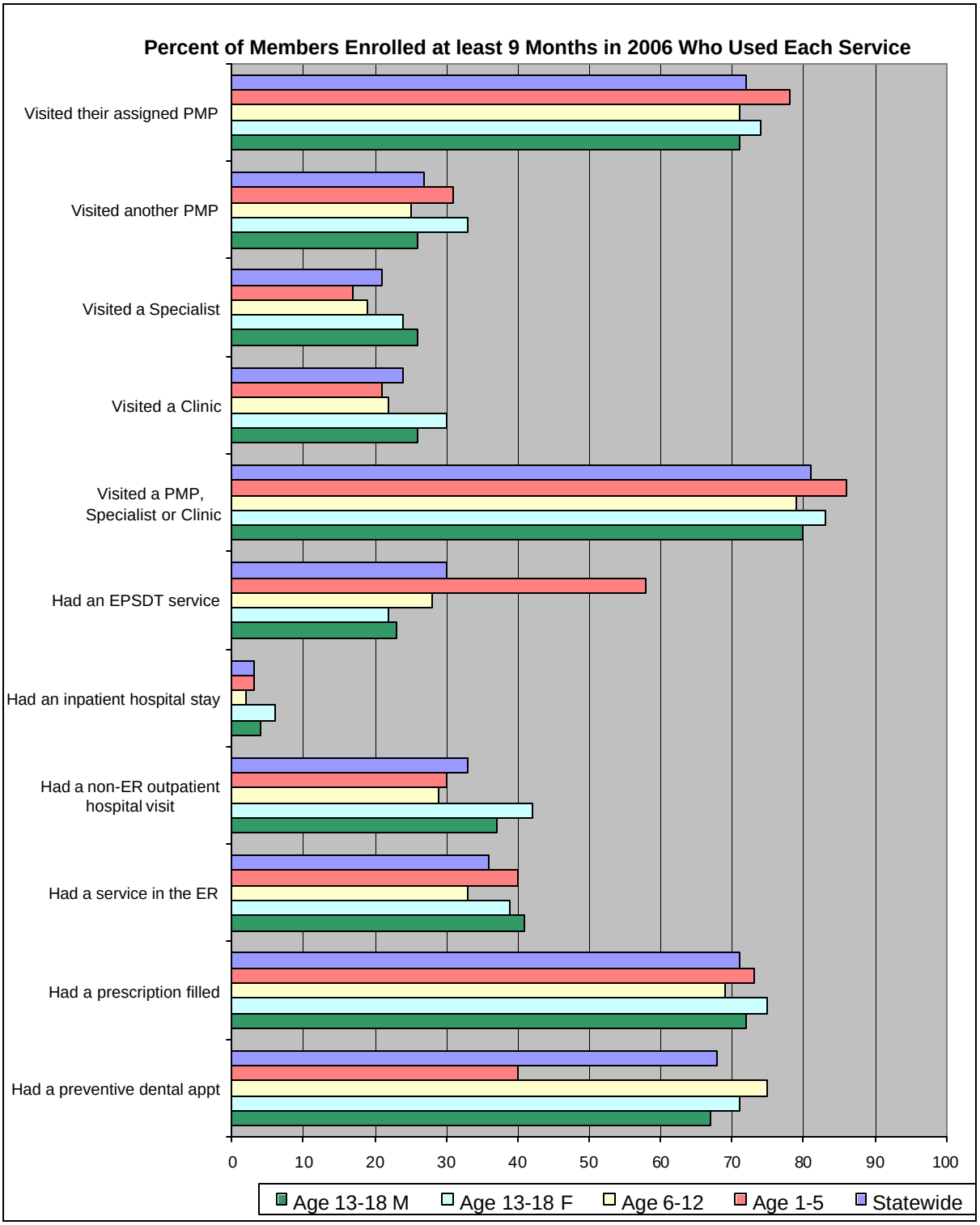


Exhibit IV.3
Utilization Statistics for CHIP Package C Children in 2006
By Age Group

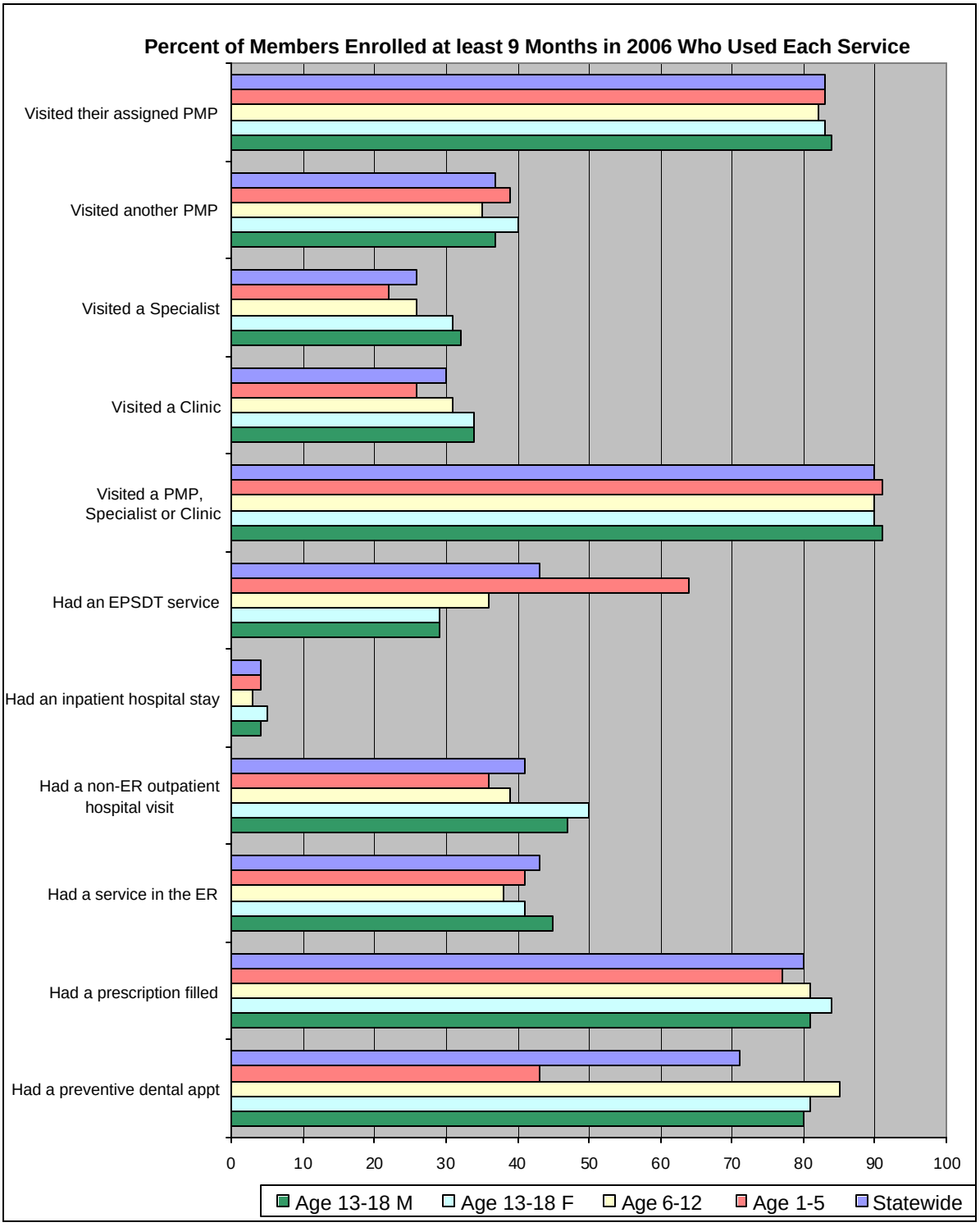


Exhibit 4: Utilization Statistics for CHIP Package A Children by MCO in 2006
Exhibit 5: Utilization Statistics for CHIP Package C Children by MCO in 2006

Exhibits 4 and 5 compare the rate of service usage of the same children shown in Exhibit 1 but divided among the five MCOs. Each member was classified into the MCO that they were assigned to at the end of each calendar year. Note that some children in Exhibit 1 were not included here because they were not assigned to an MCO. It should also be pointed out that three of the MCOs shown in these exhibits—Harmony, CareSource, and Molina were terminated as MCOs under Indiana's Hoosier Healthwise program at end of 2006. A new MCO, Anthem, has joined MHS and MDWise as the three current statewide MCOs effective January 1, 2007.

The distribution of children included in Exhibits 4 and 5 is shown below.

	MHS	MDWise	Harmony	CareSource	Molina
CHIP A	15,937 (35%)	10,724 (23%)	6,487 (14%)	7,992 (17%)	4,685 (10%)
CHIP C	5,179 (39%)	3,289 (22%)	2,148 (14%)	2,816 (19%)	1,530 (10%)

The findings for Exhibits 4 and 5 are shown together since the trends are similar by MCO in CHIP A and CHIP C.

Key findings:

(1) CareSource members had lower office visit usage than other MCOs, as seen in the rates of usage of PMPs, specialists, and clinics.

(2) The remaining four MCOs had similar rates of usage of PMP services for its members in both CHIP A and CHIP C.

(3) There was wide variation in the rate of EPSDT services reported for members across the MCOs. MDWise was much higher than the others (15 percentage points higher than the statewide average), and Harmony was also higher than the statewide average by nine percentage points. The other three MCOs reported usage below the statewide averages for CHIP A and CHIP C members.

(4) Molina and CareSource reported the non-ER outpatient hospital usage at a higher rate than the other MCOs, which were more similar in this metric.

(5) Although they are not responsible for delivering dental services, the rate at which children in CHIP A and CHIP C had a preventive dental appointment was similar across children in all MCOs.

Exhibit IV.4
Utilization Statistics for CHIP Package A Children in 2006
By MCO

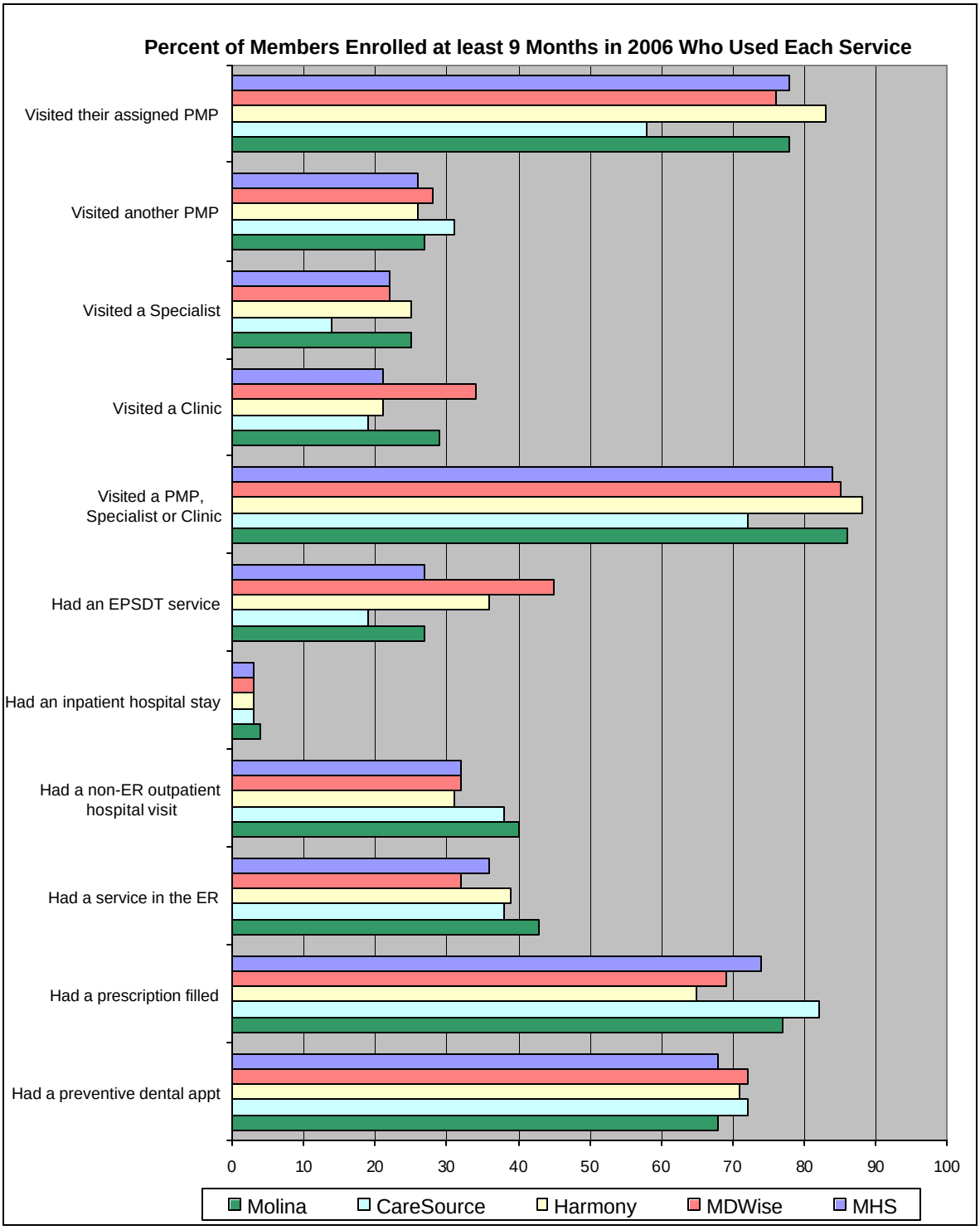


Exhibit IV.5
Utilization Statistics for CHIP Package C Children in 2006
By MCO

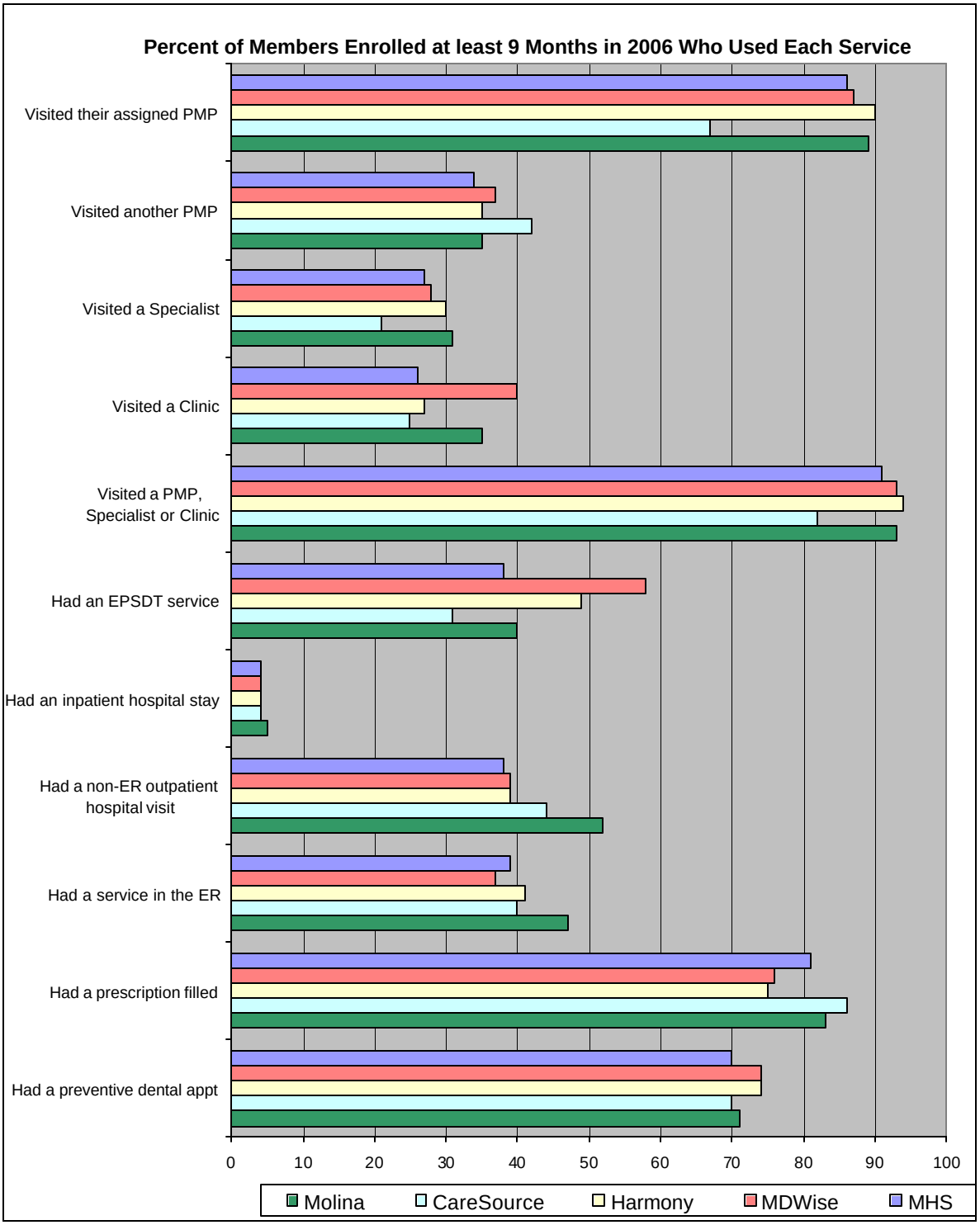


Exhibit 6: Utilization Statistics in CHIP A and CHIP C for CY 2005 and CY 2006 (new enrollees)

In this exhibit, CHIP members who were newly enrolled in CY 2005 or CY 2006 were studied to determine the types of services they received in the first three months they were enrolled. The purpose of this study was to examine if there are certain services that are prompting enrollment into CHIP and also to see if there are potential barriers to obtaining services once enrolled.

The sample of children included in the study is shown below.

	2005 Members in Exhibit	2006 Members in Exhibit
CHIP A	5,293	4,488
CHIP C	2,413	2,177

Key findings:

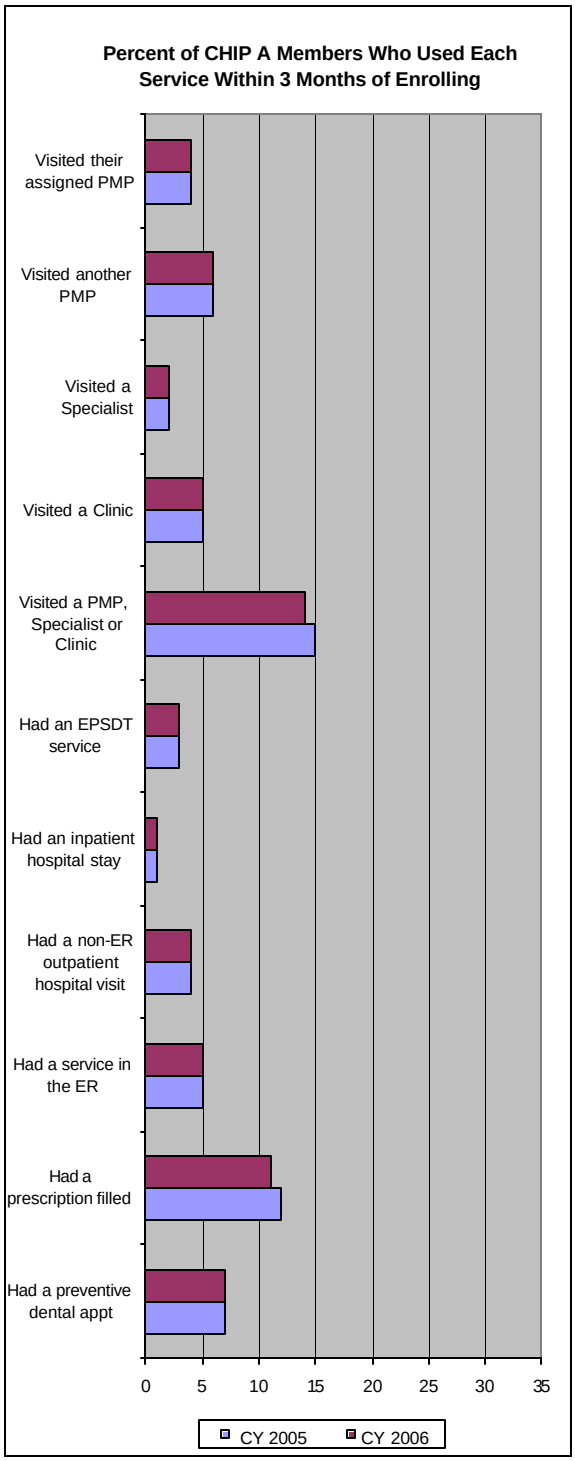
(1) As observed with the members enrolled for at least nine months of the year (refer to Exhibit #1), newly enrolled CHIP C members are more likely to use all 11 service categories studied than their peers in CHIP A.

(2) The services with the highest rate of utilization among new CHIP C enrollees are EPSDT, clinic, and prescription drugs. None of these services exceeded 20% usage by members in their first three months, however. CHIP A members were most likely to have obtained a prescription drug.

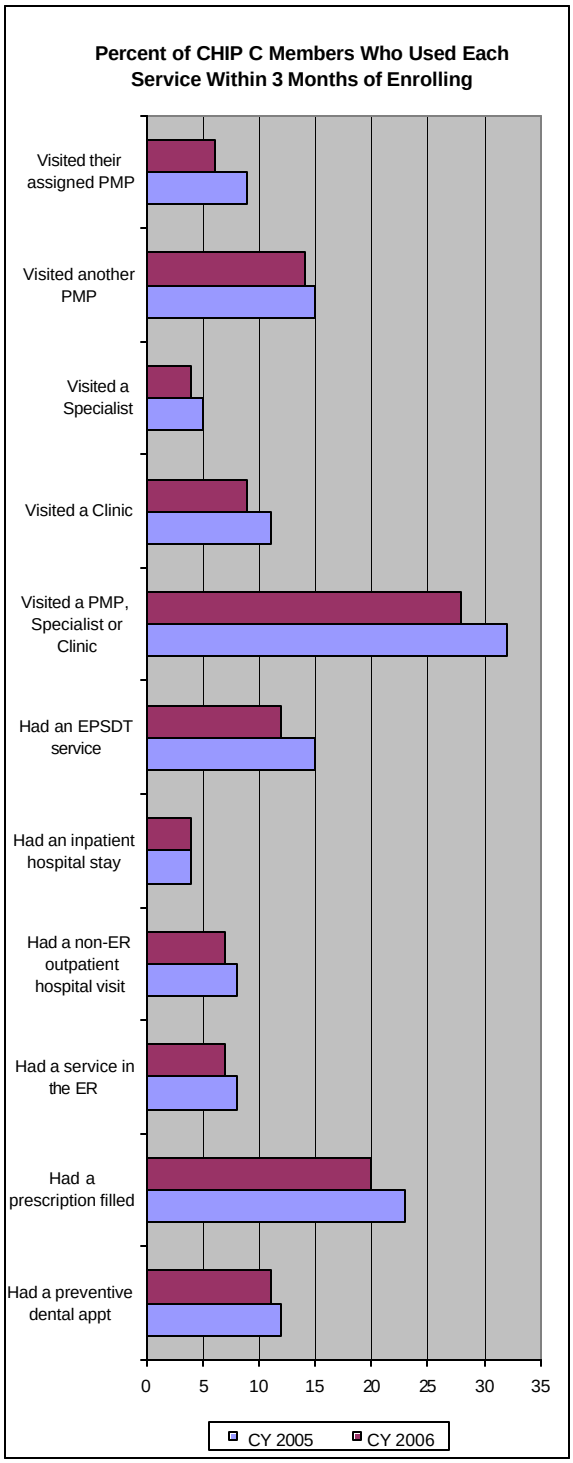
(3) Given the relatively low usage across all of the services studied, it does not appear that children are enrolling in CHIP due to a specific medical event, such as a hospitalization (only 4% of CHIP C children and only 1% of CHIP A children had an inpatient stay) or high ER usage (5% for both CHIP A and 7% for CHIP C).

(4) The low percentage of children seeing their assigned PMP within the first three months of enrollment suggests that the CHIP Office may want to work closely with the MCOs to encourage parents to set up an appointment with their child's PMP as soon as the PMP is selected or assigned. The waiting time to set an appointment should also be reviewed, as this may be the reason for low PMP usage.

Exhibit IV.6
Utilization Statistics in CHIP A and CHIP C
Statewide Totals



2005 sample= 5,293; 2006 sample= 4,488



2005 sample= 2,413; 2006 sample= 2,177

Exhibit 7: Utilization Statistics for CHIP A New Enrollees by Age Group in 2006
Exhibit 8: Utilization Statistics for CHIP C New Enrollees by Age Group in 2006

Exhibits 7 and 8 compare the rate of service usage of the same children shown in Exhibit 6 but divided into the four age groups.

The sample of children included in Exhibits 7 and 8 is distributed similar to the children with at least nine months of enrollment that were shown in Exhibits 2 and 3.

	Age 1-5	Age 6-12	Age 13-18 Female	Age 13-18 Male
CHIP A	627 (14%)	2,164 (48%)	988 (22%)	701 (16%)
CHIP C	611 (32%)	771 (40%)	260 (14%)	280 (15%)

Key findings:

(1) The low percentage of children reported in Exhibit 6 found to have seen their assigned PMP was relatively consistent across age groups in both CHIP A and CHIP C.

(2) Among the highest utilized services among new CHIP C members (EPSDT, clinic, and prescription drugs), usage of clinic and prescription drugs was similar across age groups. The EPSDT services were found, as expected, to be much higher among children ages 1-5.

(3) Similar to what was found for longer-tenured members (refer to Exhibits 2 and 3), newly-enrolled teenagers were more likely to have received a non-ER outpatient hospital service or a clinic service than younger CHIP members.

Utilization Statistics for CHIP New Enrollees by MCO in 2006

Exhibits showing utilization by MCO are not presented since over 30% of the newly enrolled members identified in 2006 had yet to be assigned an MCO. Among those that were assigned to an MCO, the findings for new members across MCOs was similar to what was found for longer-tenured members (refer to Exhibits 4 and 5). Specifically, CareSource members had lower physician and office visit usage than other MCOs, while MDWise reported more members receiving an EPSDT service.

Exhibit IV.7
Utilization Statistics for CHIP Package A Children in 2006
By Age Group

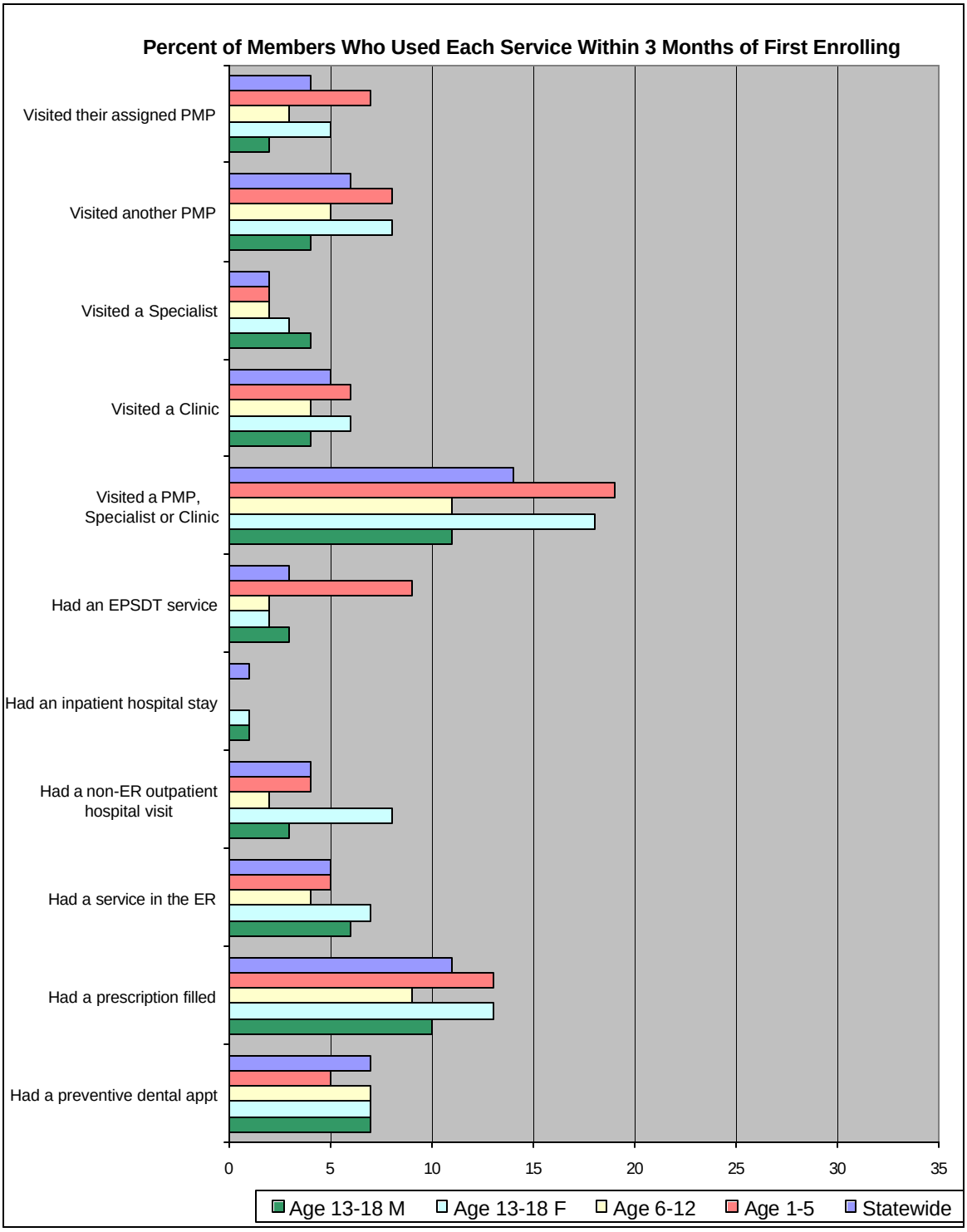
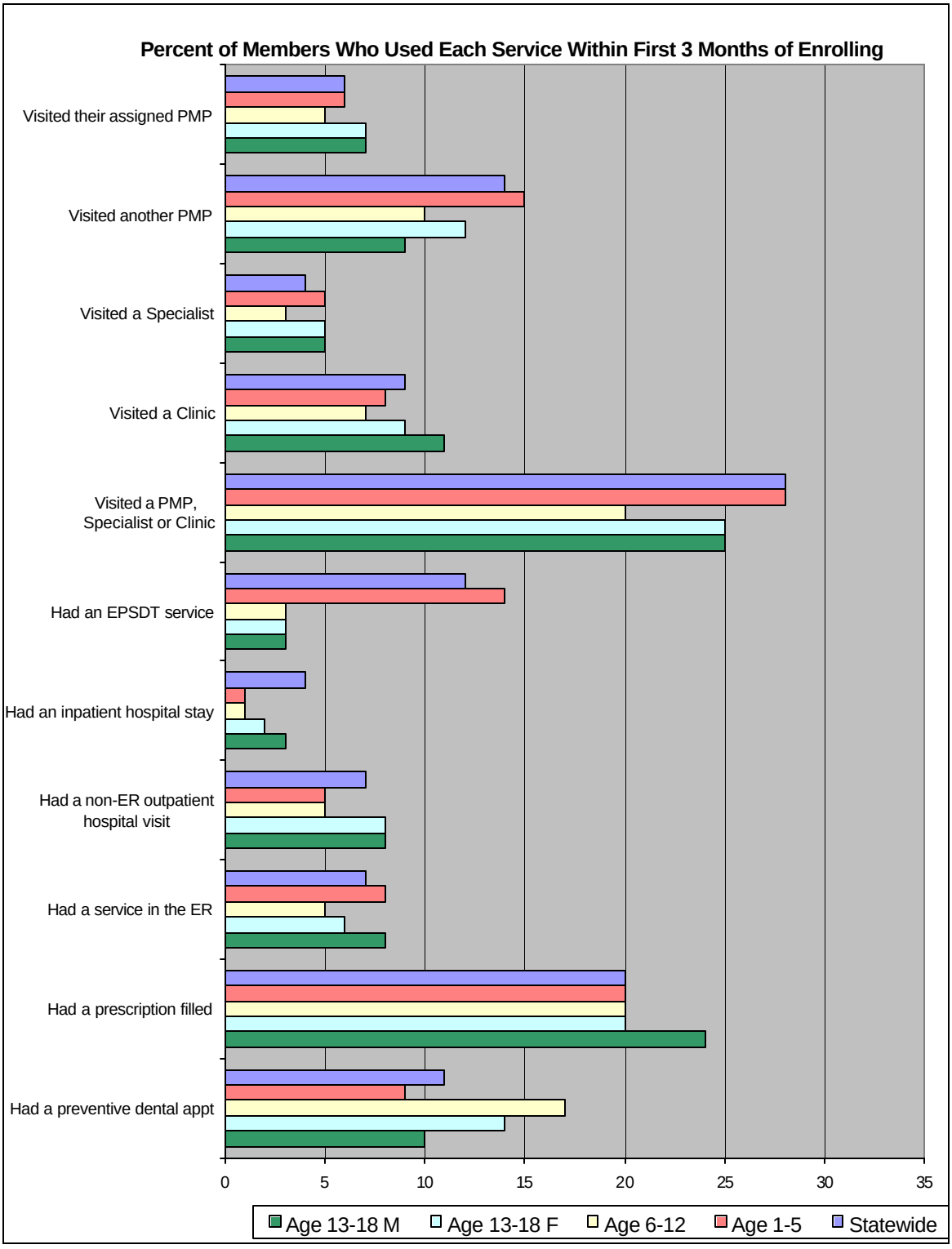


Exhibit IV.8
Utilization Statistics for CHIP Package C Children in 2006
By Age Group



V. Prevalence and Utilization of Children with Specific Diagnoses in Indiana's CHIP

Chapter Highlights

- With prevalence defined as having a diagnosis for the condition in any of the past five years, the prevalence of members with behavioral disorders is 25% - 30% among anyone enrolled in CHIP at some point during 2005 or 2006. Asthma prevalence is 16% to 17%, and the prevalence of members with obesity diagnoses is 4% - 4.5%.

- The prevalence of members with an asthma, behavioral disorder, or obesity diagnosis is similar between CHIP A and CHIP C. Across all three diagnosis categories, the prevalence fell significantly from 2005 to 2006, but this is most likely due to the fact that new enrollees in 2006 would have had less time to access services than new enrollees in 2005 (service use was studied through December 2006 for all children).

- Patterns of utilization in 2006 were similar among all three groups studied. In each group, members that had been diagnosed with the disorder were about twice as likely to use clinics, emergency rooms, outpatient services, inpatient services, and prescriptions as those children without one of these diagnoses.

- Emergency room utilization and inpatient hospital stays being the biggest concern, services used by these children should be studied to determine what percentage of the services might have been preventable.

- The level of prevalence combined with the level of utilization by members in these categories, especially members with behavioral disorders, means that they account for a large percentage of the utilization in the CHIP program as a whole. If better monitoring of this population reduced the number of preventable but intensive services, the State could achieve significant cost savings.

Introduction

Children diagnosed with certain conditions, such as asthma, warrant special attention for their additional health needs. Children with asthma, for example, depend on the health infrastructure more than the average child, and are therefore affected more by decisions related to access to physicians and the cost of prescriptions. These children also use more services and account for higher expenditures.

In this section, Burns & Associates (B&A) analyzes the enrollment and utilization of children who have a diagnosis on a submitted claim or encounter in one of three categories:

(1) Asthma (ICD-9 Diagnoses 493.xx)
(2) Behavioral Disorders (ICD-9 Diag. 290.xx – 299.xx and 300.xx – 316.xx)
(3) Obesity (ICD-9 Diagnoses 278.0, 783.1 and 783.6)

Behavioral disorders includes psychoses diagnoses (290.xx – 299.xx) and diagnoses not related to psychoses (300.xx – 316.xx). The former includes conditions such as schizophrenia, while the latter includes conditions such as depression and substance abuse.

Prevalence

The prevalence of children with these diagnoses is shown in the next two tables for members who were enrolled at any point during 2005 or 2006. For the purposes of this section, prevalence is defined as having been diagnosed with the condition within the last five years. This is in contrast to current prevalence, or point-in-time prevalence, which would require a member survey. Overall, prevalence rates are similar between CHIP A and CHIP C with the behavioral disorders being the most commonly diagnosed at 30%. The prevalence of asthma is about 16% in both populations, and the prevalence of obesity is about 4%.

Across all three categories the prevalence of these diagnoses fell significantly between CY 2005 and CY 2006, while the total CHIP population growth was flat. However, since we are using claims history to identify these children, children who were new to the program in 2006 would not have the same amount of time to access services as children new to the program in 2005. This discrepancy is probably causing the 2006 numbers to be understated compared to 2005.

CHIP A

	Asthma Diagnosis (Number and % of Population)	Behavioral Health Diagnosis (Number and % of Population)	Obesity Diagnosis (Number and % of Population)	Total CHIP A Population (Ever Enrolled in the year)
CY 2005	16,412 16.3%	32,456 32.2%	4,822 4.8%	100,796
CY 2006	16,564 16.0%	30,911 29.9%	4,518 4.4%	103,531
Percent Change 05-06	0.9%	-4.8%	-6.3%	2.7%

CHIP C

	Asthma Diagnosis (Number and % of Population)	Behavioral Health Diagnosis (Number and % of Population)	Obesity Diagnosis (Number and % of Population)	Total CHIP C Population (Ever Enrolled in the year)
CY 2005	6,411 17.4%	10,071 27.3%	1,587 4.3%	36,917
CY 2006	6,215 16.7%	9,440 25.3%	1,442 3.9%	37,261
Percent Change 05-06	-3.1%	-6.3%	-9.1%	0.9%

Compared to a national report on asthma for children ages 0-17, Indiana's CHIP seems to have higher prevalence rates for asthma. This report shows a lifetime prevalence rate for the disease at 12.7% nationally and a current prevalence rate of 8.9% nationally in 2005. Indiana's current prevalence rate in 2005 was 8.4%.[1] Note that these figures are for the entire state child population, whereas B&A has studied just the CHIP population.

Services Studied

The exhibits in this section show utilization patterns for children with and without the identified diagnoses. To control for differences in the CHIP A and CHIP C enrollment figures, the utilization measure used for this section is the number of services performed per 1,000 members. Any member enrolled during the year was counted in the base of the measure. As in prior sections, B&A has included both capitated

[1] The State of Childhood Asthma, United States, 1980-2005, Centers for Disease Control and Prevention, National Center for Health Statistics, Advance Data, Number 31, Revised Dec. 29, 2006

services provided through the MCO and services provided outside the capitation agreement, such as certain behavioral health drugs or inpatient psychiatric care within the covered general acute hospital care service.

This section focuses on more intensive service categories which tend to be utilized more by children with these types of diagnoses. The services considered are:

Specialist visits per 1,000 members	Includes services not performed by a physician who is not the member's PMP, not considered a PMP using OMPP's definition of a PMP, and is not an ER doctor.
Clinic visits per 1,000 members	Members may receive services in a clinic (free-standing or hospital-based) in addition to or in lieu of their PMP's office. However, if the member's PMP has their primary location at a clinic, these services are not included in this category.
Inpatient hospital stays per 1,000 members	Any overnight stay in the hospital.
ER visits per 1,000 members	Any outpatient service billed by a hospital with an emergency room revenue code. The service may be deemed emergent or non-emergent.
Non-ER outpatient hospital visits per 1,000 members	Other hospital services outside the ER and clinic performed as an outpatient.
Prescriptions filled per 100 members	These are identified by specific claims submitted by MCOs or pharmacies. Reported per 100 members because of a high number of claims for this service.

Exhibit 1: Utilization by CHIP A and CHIP C Members with Asthma

Exhibit 1 compares utilization rates between members with asthma and members without asthma for both CHIP A and CHIP C. Statistics are shown for members enrolled at any time during 2006.

The sample of children included in the exhibit is shown below.

	2006 Members with Asthma in Exhibit	2006 Members without Asthma in Exhibit	2006 Total
CHIP A	16,564	86,967	103,531
CHIP C	6,215	31,046	37,261

Key findings:

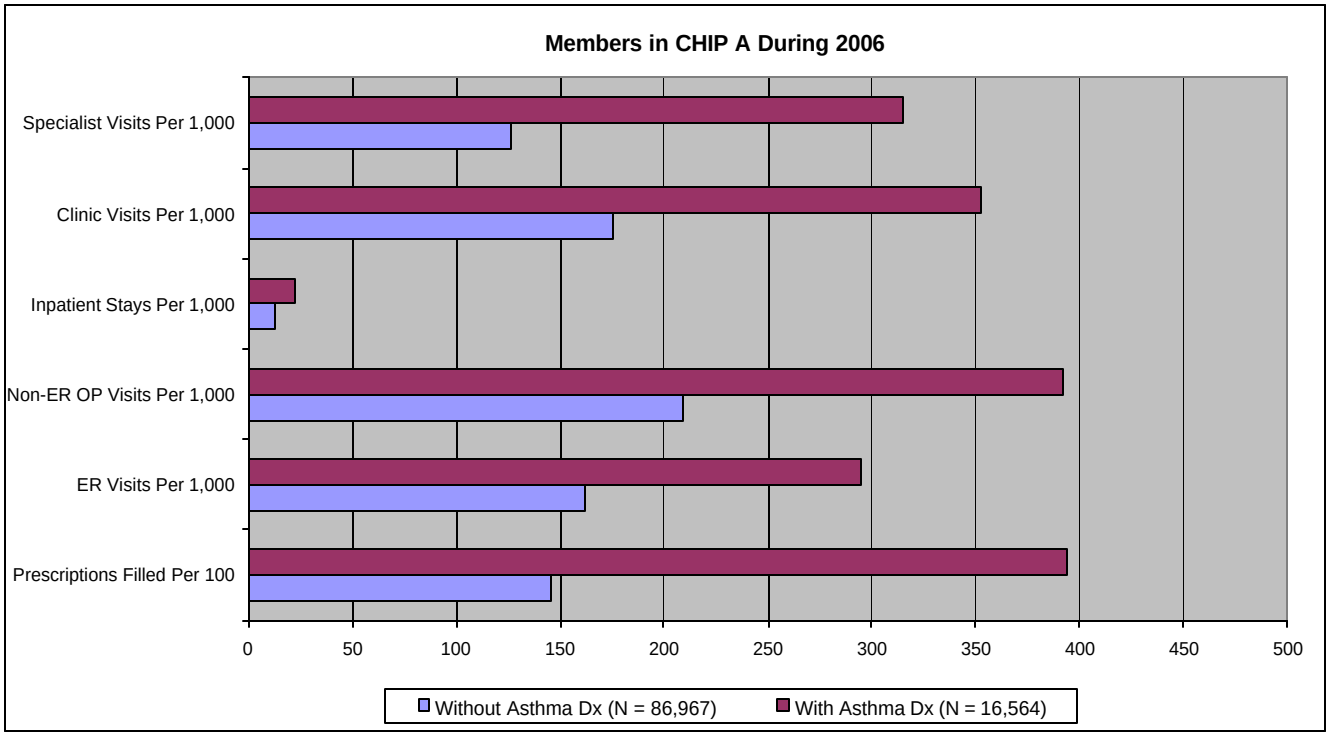
(1) Members with asthma in both CHIP A and CHIP C visit clinics, emergency rooms and other outpatient settings at about twice the rate that members without asthma do. Members with asthma are also twice as likely to be admitted to the hospital for an overnight stay

(2) Pharmacy utilization is about two and a half times higher for members with asthma (394 claims per 100 CHIP A members and 381 claims per 100 CHIP C members) compared to members without asthma.

(3) CHIP C members with asthma visited specialist physicians, clinics, and had more outpatient services than CHIP A members with asthma, but CHIP A members with asthma were more likely to visit the ER and had slightly more pharmacy claims.

(4) Many of the ER visits and inpatient stays may be preventable for children with asthma. The CHIP Office should work with MCOs to find better ways of identifying and monitoring these children to try and reduce the number of preventable hospitalizations.

Exhibit V.1
Utilization Statistics in CHIP A (Medicaid expansion) and CHIP C (Premium-based)
Members with and without Asthma Diagnoses



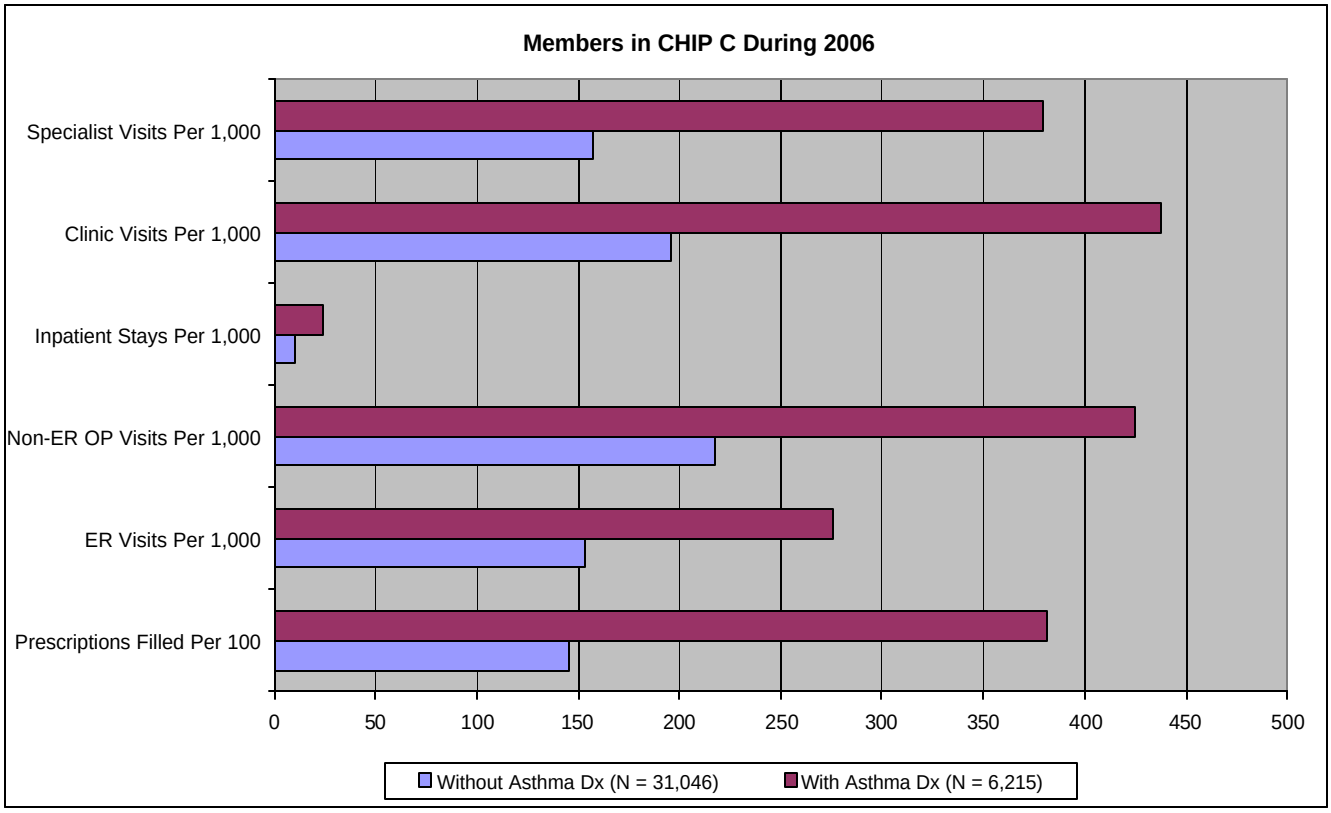


Exhibit 2: Utilization by CHIP A and CHIP C Members with Behavioral Disorders

Exhibit 2 compares utilization rates between members with behavioral disorders and members without behavioral disorders for both CHIP A and CHIP C. Statistics are shown for members enrolled at any time during 2006.

The sample of children included in the exhibit is shown below.

	2006 Members with Behavioral Disorders in Exhibit	2006 Members without Behavioral Disorders in Exhibit	2006 Total
CHIP A	30,911	72,620	103,531
CHIP C	9,440	27,821	37,261

Key findings:

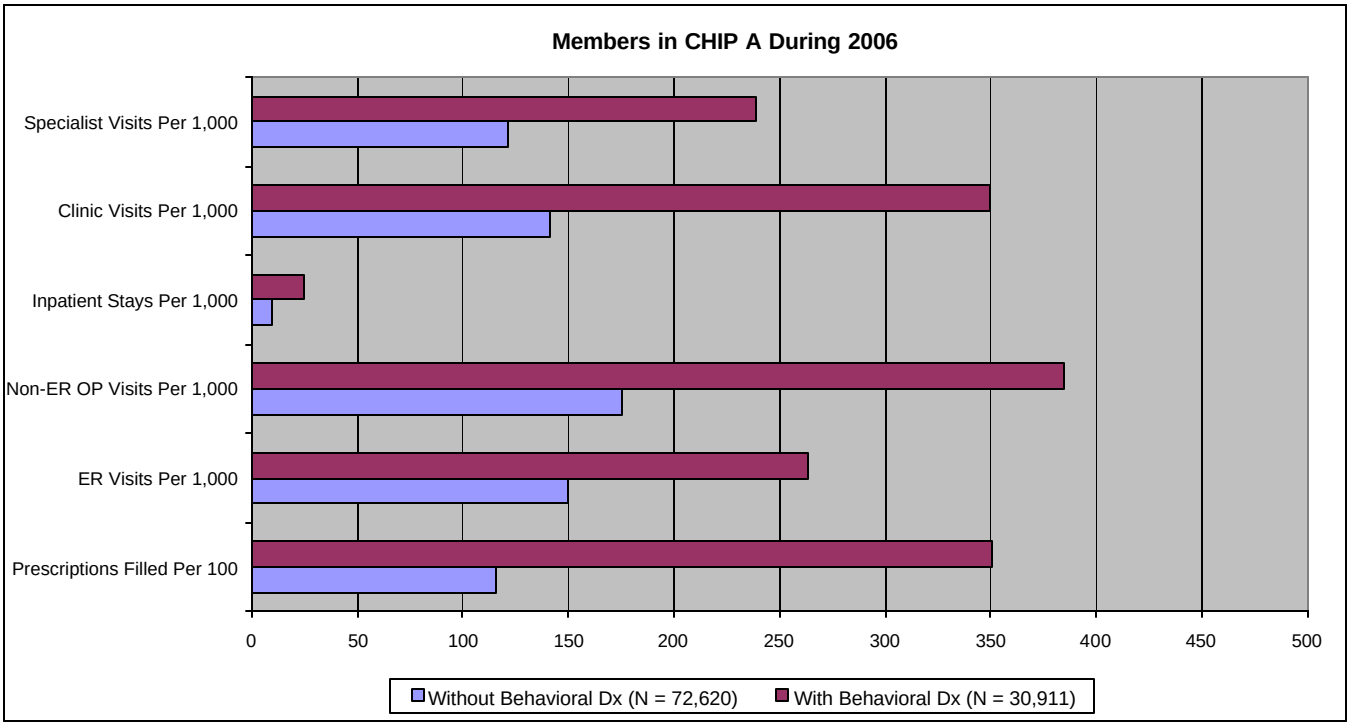
(1) Members with behavioral disorders, like members with asthma, show much higher utilization of outpatient services, clinics, drugs, and inpatient hospital stays, but behavioral disorders are more prevalent in the CHIP population than asthma is (30% of CHIP A members and 25% of CHIP C members).

(2) Emergency room utilization among CHIP C members with behavioral disorders is only 40% higher than CHIP C members without behavioral disorders, whereas it is 75% higher for CHIP A members with behavioral disorders.

(3) The number of inpatient stays for CHIP A members with behavioral disorders is particularly high at 25 inpatient stays per 1,000. This is two and half times the average rate for CHIP A members without behavioral disorders, and it is almost 20% higher than CHIP C members with behavioral disorders.

(4) The behavioral disorders considered here cover a wide range of diagnoses, from depression to substance abuse to schizophrenia. There is a high prevalence rate among this population of these diagnoses and these diagnoses lead to service utilization rates comparable to children with asthma. More work needs to be done to identify any particular diagnosis that might be driving the service utilization.

Exhibit V.2
Utilization Statistics in CHIP A (Medicaid expansion) and CHIP C (Premium-based)
Members with and without Behavioral Diagnoses



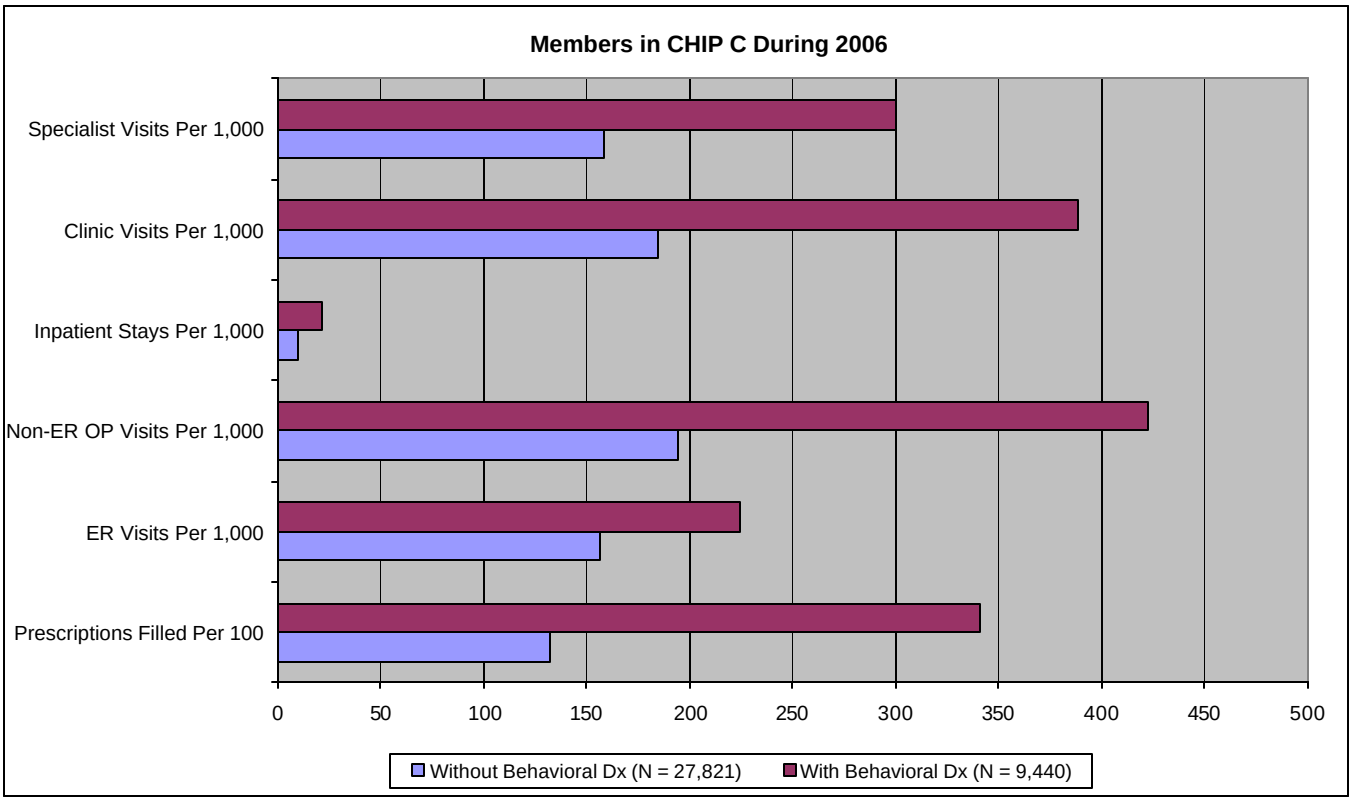


Exhibit 3: Utilization by CHIP A and CHIP C Members Diagnoses with Obesity

Exhibit 3 compares utilization rates between members with obesity and members without obesity for both CHIP A and CHIP C. Statistics are shown for members enrolled at any time during 2006.

The sample of children included in the exhibit is shown below.

	2006 Members with Obesity in Exhibit	2006 Members without Obesity in Exhibit	2006 Total
CHIP A	4,518	99,013	103,531
CHIP C	1,442	35,819	37,261

Key findings:

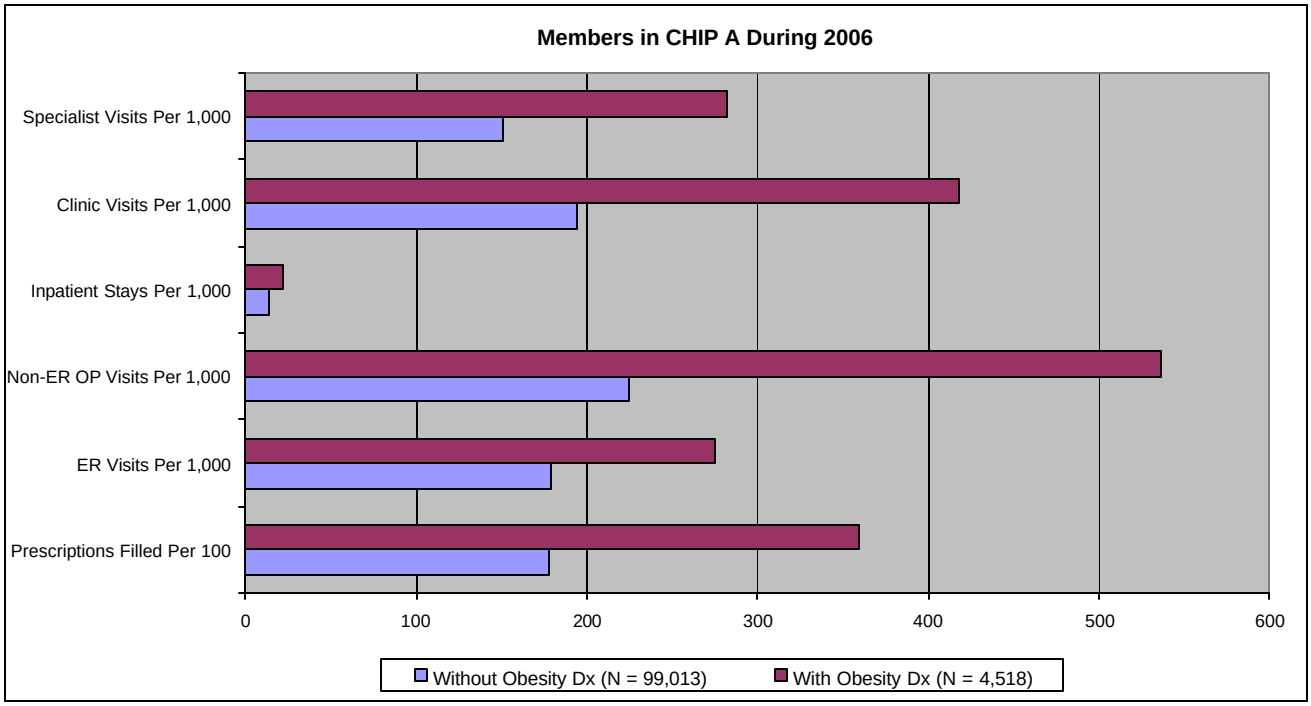
(1) The prevalence of members with diagnoses for obesity was lower than that of asthma or behavioral disorders (4.4% of CHIP A had a diagnosis for obesity and 3.9% of CHIP C had a diagnosis for obesity).

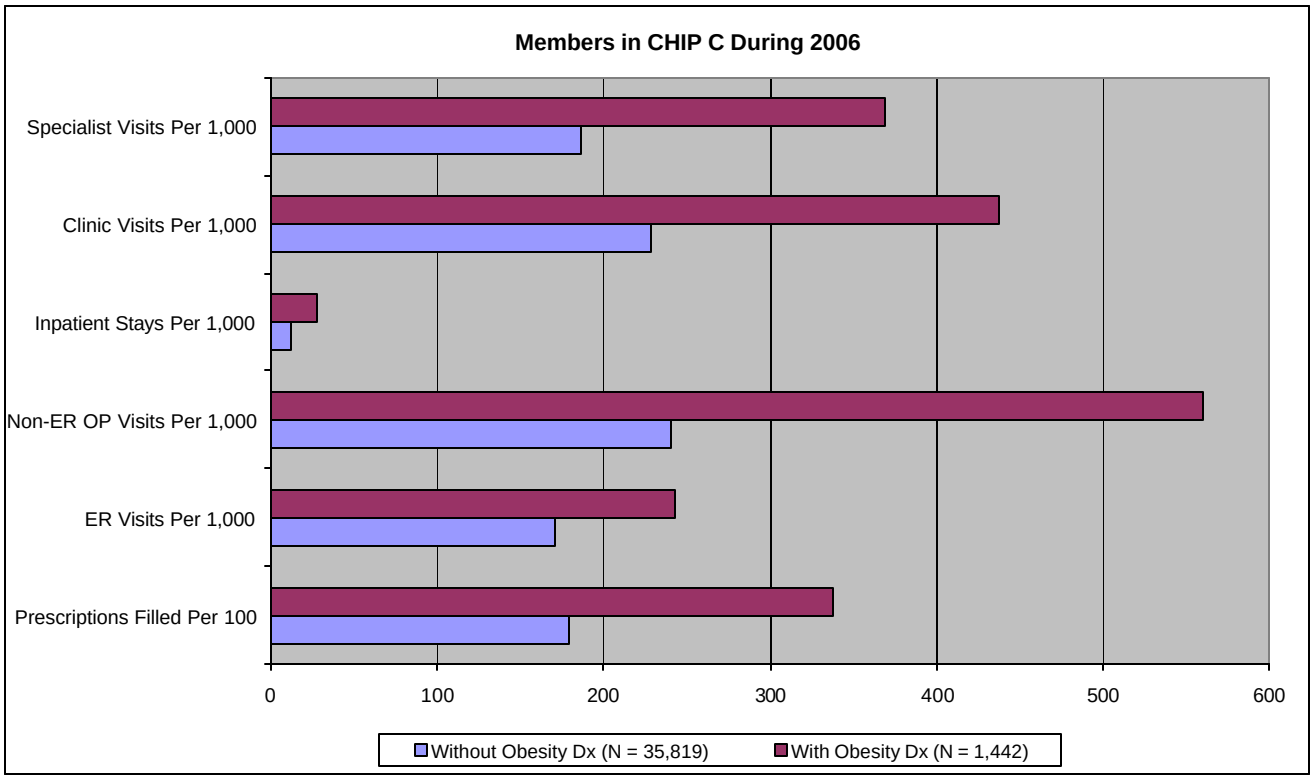
(2) Members with obesity had the highest rates of outpatient utilization among any of the groups considered (537 outpatient visits per 1,000 for CHIP A members with obesity and 560 outpatient visits per 1,000 for CHIP C members with obesity).

(3) Rates of utilization for the other services considered are about as high for members with obesity as they are for members with behavioral disorders. They have comparable numbers of pharmacy claims, clinic visits, emergency room visits and inpatient stays.

(4) As with members with asthma and behavioral disorders, members with obesity warrant special attention and further study to determine how much of this utilization might be preventable by better care.

Exhibit V.3
Utilization Statistics in CHIP A (Medicaid expansion) and CHIP C (Premium-based)
Members with and without Obesity Diagnoses





VI. Comparisons to National Benchmarks

Chapter Highlights

- Chapter IV discussed what appeared to be opportunities for improvement of services to CHIP members related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, which are guidelines set by the State for all children to receive checkups and screenings at regular intervals over the course of their development. When compared to other Indiana data and national benchmarks, CHIP C members have lower participation rates for EPSDT than their peers in 2005 and 2006. This is a reduction from 2004, when CHIP C results were more similar to national and overall Hoosier Healthwise trends.

- Results from ratings of each health plan for Health Plan Employer Data and Information Set (HEDIS) measures were overall positive for the Hoosier Healthwise child population. (CHIP members are not specifically categorized in these ratings.) Indiana's MCOs were compared against each other as well as the national median rate which is the percentage of children receiving a specific service or treatment. The Hoosier Healthwise MCOs exceeded the national median on measures such as access to primary care practitioners, well child visits in the first 15 months of life, well child visits for younger children and for adolescents, appropriate treatment for children with upper respiratory infection, and use of appropriate medications for children with asthma. Results were lower from Indiana's MCOs for appropriate testing for children with strep throat and for adolescent immunizations. There were mixed results at the health plan level for childhood immunization rates when compared to the national median rate.

- Indiana's MCOs contracted with a survey administrator in 2006 to survey the parents of children in Hoosier Healthwise using a standardized survey tool used by Medicaid health plans nationwide. Across nine composite satisfaction measures, Indiana's statewide rates (all MCOs combined) were higher than the national averages. The only measure lower than the national average was customer service (67.9% favorable rating for Indiana and 72.1% for national). Also, on four of the nine composite measures, some Indiana MCOs had ratings that were statistically significantly higher than the national average. Only one health plan (CareSource) has a statistically lower rating than national for customer service.

Introduction

There are a number of national data sources which states can use to measure against with respect to the access, utilization, and quality of services they provide to children. Some in particular capture national data with respect to children in Medicaid and SCHIP programs. There are no national sources with meaningful samples that capture CHIP-specific data. But many state Medicaid programs include their CHIP programs as well when measuring specific benchmarks related to children.

Three of these sources were used by Burns & Associates to measure Indiana's CHIP members against other state Medicaid/CHIP programs. These include:

(1) The Center for Medicare and Medicaid's (CMS) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Participation Report. This annual report is required by CMS to be submitted by all Medicaid programs on an annual basis. All programs report on various screenings in the same manner so that data can be aggregated at the national level. The Office of Medicaid Policy and Planning's fiscal agent, EDS, compiles the report on behalf of OMPP for all Hoosier Healthwise children and for the CHIP C program separately.

(2) The National Committee for Quality Assurance's (NCQA) HEDIS measures®[1]. The Health Plan Employer Data and Information Set, better known as HEDIS, is the most widely used set of performance measures in the health care industry. The NCQA collects data from both private sector and Medicaid health plans on a variety of measures on an annual basis. For each measure, Medicaid agencies are able to compare their results against national benchmarks reported by other Medicaid health plans. The method of collecting HEDIS data is highly regulated by NCQA-certified firms to ensure data integrity. Indiana required all of its Medicaid MCOs to collect HEDIS results on specific HEDIS measures in 2006.

(3) The Agency for Healthcare Research and Quality's Consumer Assessment of Health Plans (CAHPS)®[2] Medicaid Child Member Satisfaction Survey. This survey is administered by mail and by phone on an annual basis by a number of Medicaid agencies and their health plans to determine members' satisfaction (by surveying their parents) with their medical providers and their health plan. Indiana required all of its Medicaid MCOs to administer the CAHPS survey in 2006. Each MCO used the same survey and survey administrator to assure data integrity across plans.

The results of how Indiana's Hoosier Healthwise program (including CHIP) compared to national benchmarks is discussed below.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance
[2] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality

EPSDT Survey

The EPSDT participation report tabulates the number of children in the program studied, divided into seven age groups: <1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20. Each state defines its recommended screening schedule which specifies what screenings should be given at each age and how often. The Medicaid agency is instructed to calculate the number of expected screenings that should be reported at each age group based on the number of children in the age group and the screening schedule. More screenings are required in the younger years. For example, Indiana's screening schedule recommends the following:

Age <1: 7 screens
Age 1-2: 4 screens
Age 3-5: 3 screens
Age 6-9: 2 screens
Age 10-14: 3 screens
Age 15-18: 2 screens
Age 19-20: 1 screen

A screening ratio is calculated that tabulates the rate of screenings actually received as compared to the suggested number of screenings. This ratio is computed for each age group separately. Since younger age groups are suggested to receive multiple screenings in one year, the ratio can be greater than 1.0.

A participant ratio is also calculated which simply reflects the percentage of children in each age group that received at least one screening in the year. The maximum ratio for any age group is 100%.

Indiana's CHIP C EPSDT participant and screening ratios were compared to Indiana's Hoosier Healthwise program in general as well as national results. Data from the two Indiana programs was reviewed for the years 2004, 2005 and 2006. Comparisons to national data were completed for 2004 and 2005 (most recent available).

As seen in the exhibits on the next page, the results for CHIP C in 2006 are significantly lower than those reported for Hoosier Healthwise children in general.

Exhibit VI.1
Participant Ratio for EPSDT Services- 2006

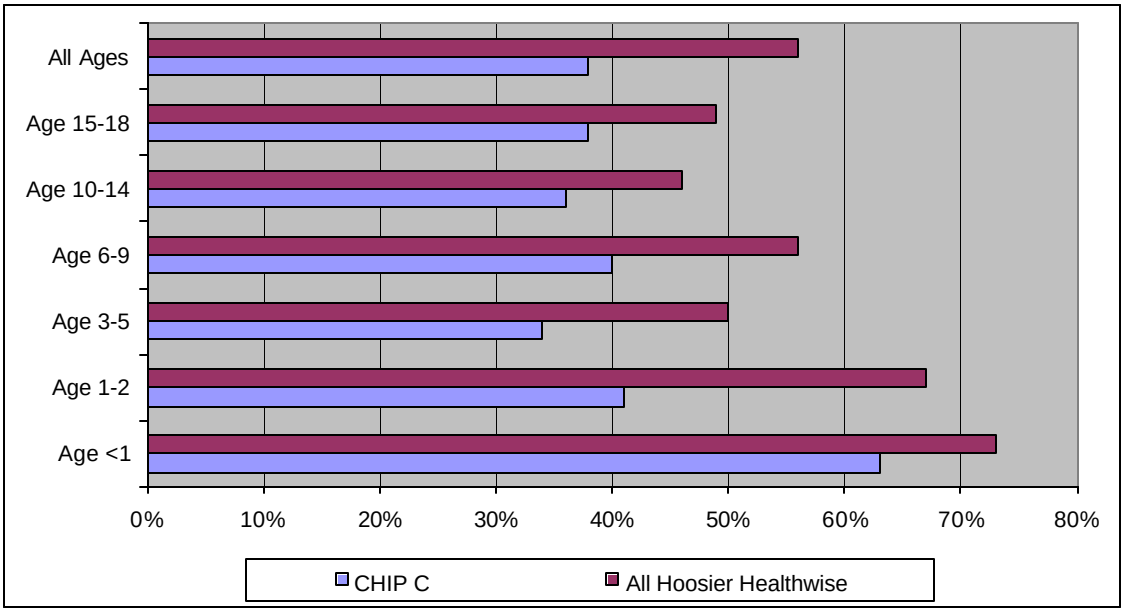
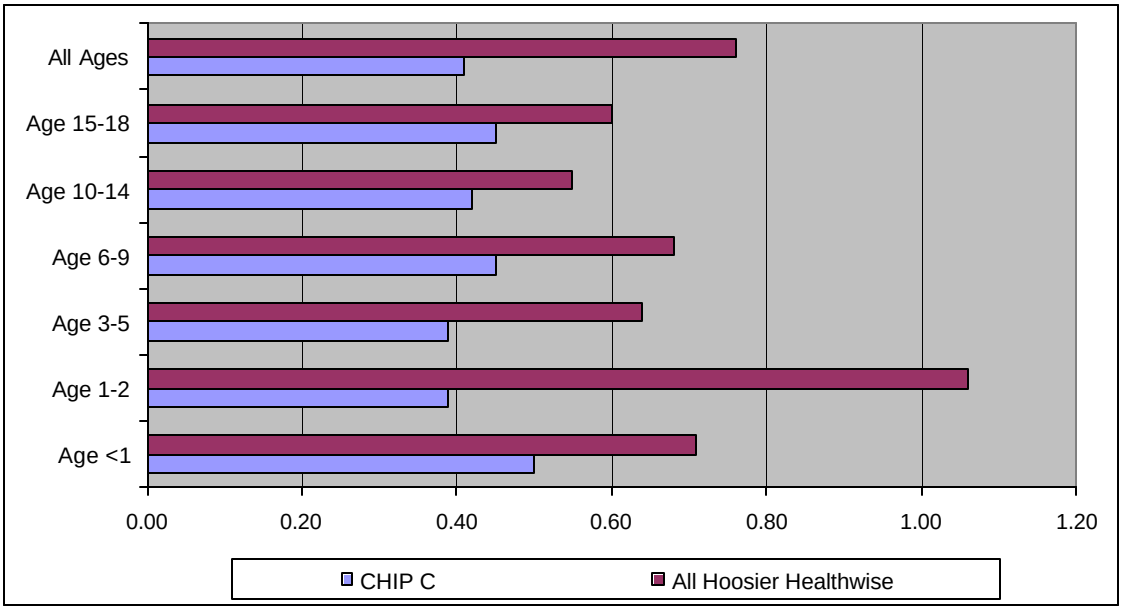


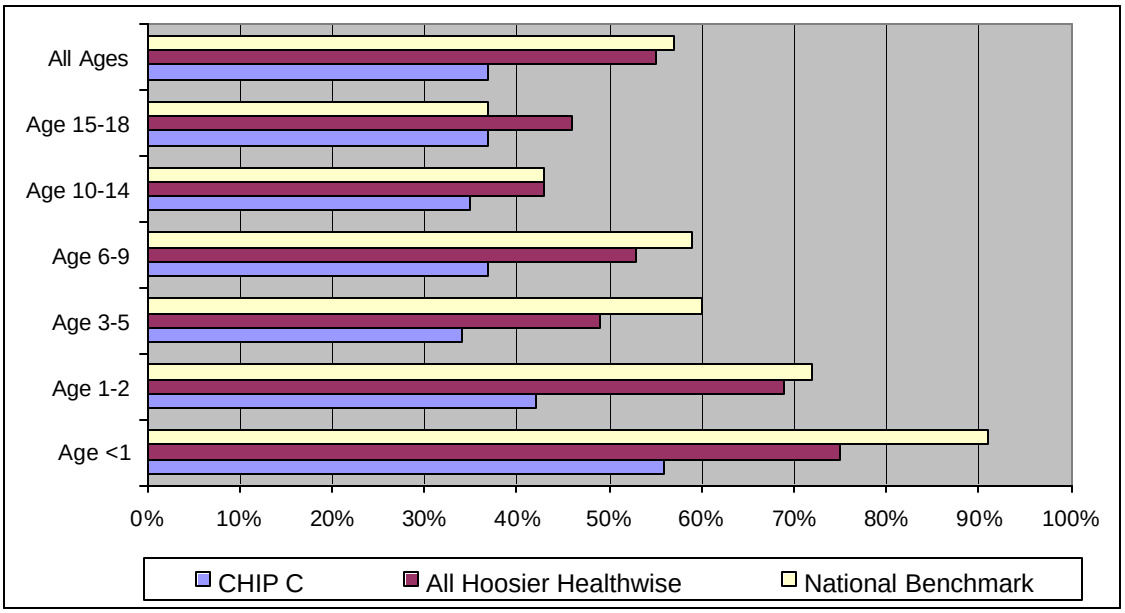
Exhibit VI.2
Screening Ratio for EPSDT Services- 2006



CHIP C also reported lower participant ratio and screening ratio rates in 2005 than those found for all Hoosier Healthwise children. When compared to national benchmarks, Hoosier Healthwise exceeded national results for teenagers, was

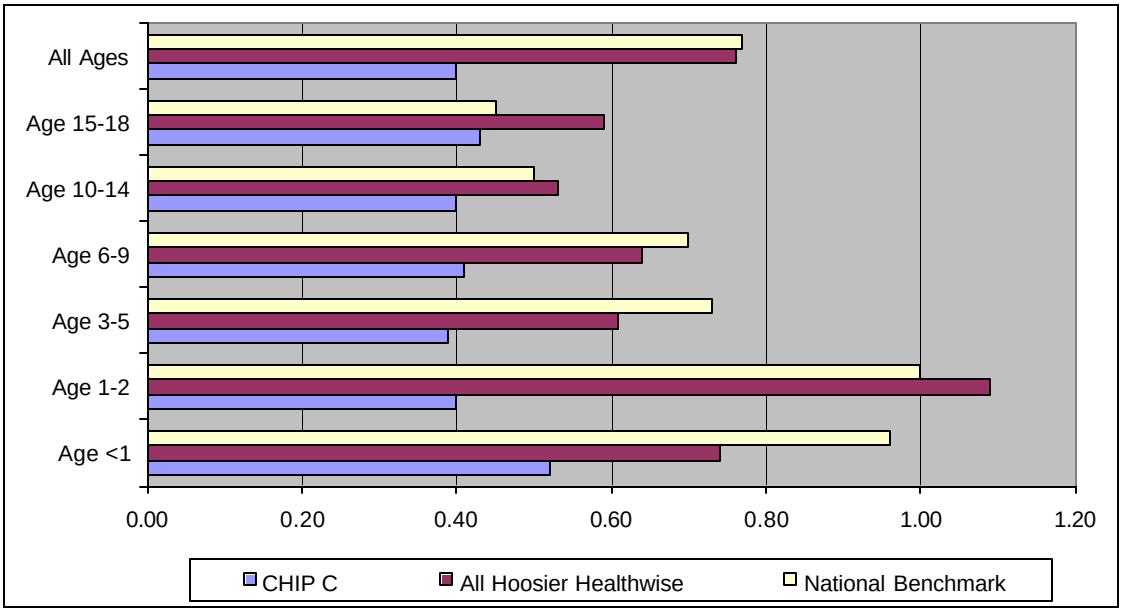
similar to national results for children ages 10-14 and 1-2, but lower than national figures for infants, ages 3-5, and ages 6-9.

Exhibit VI.3
Participant Ratio for EPSDT Services- 2005



The screening ratio results were similar to the participant ratio results, with the exception of ages 1-2, where Hoosier Healthwise exceeded the national figure.

Exhibit VI.4
Screening Ratio for EPSDT Services- 2005



Results were different in 2004 for CHIP C, particularly with the participant ratio. CHIP C results were better than all Hoosier Healthwise and, for most age groups, the national benchmarks. The screening ratios were not as successful for CHIP C when compared to Hoosier Healthwise or national figures. Exhibit VI.5 suggests that more CHIP C children received at least one screen than the other programs, but Exhibit VI.6 suggests they did not receive as many recommended screenings as other programs.

Exhibit VI.5
Participant Ratio for EPSDT Services- 2004

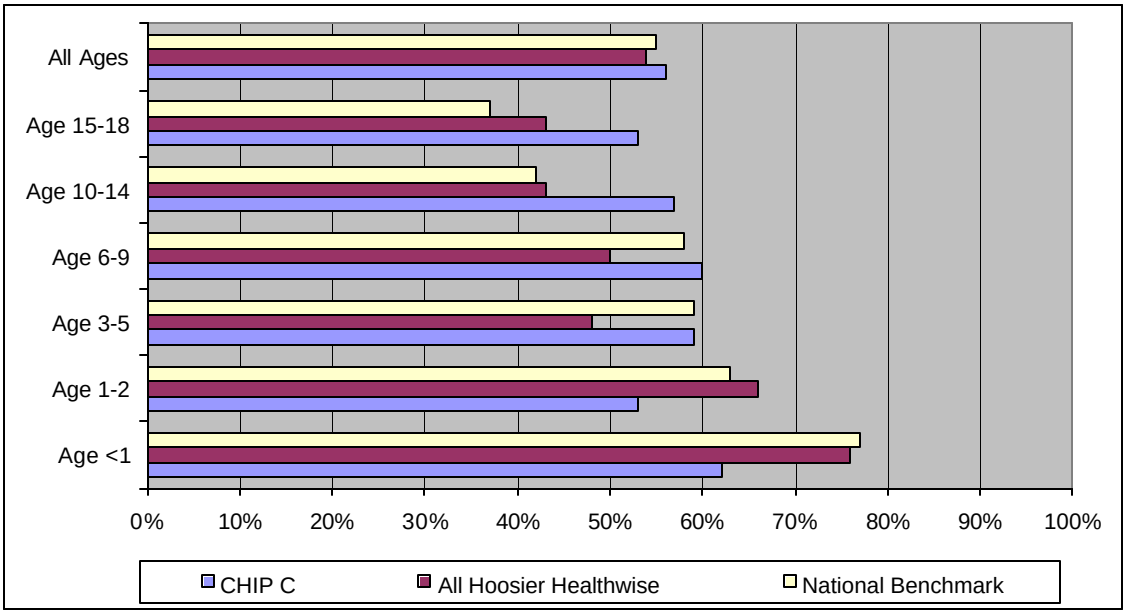
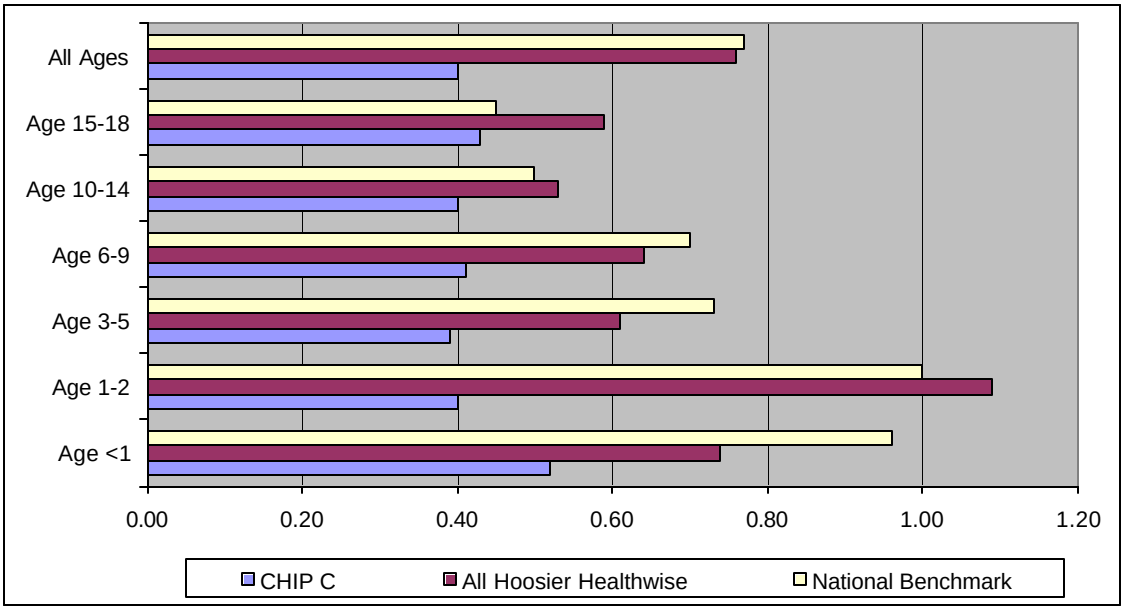


Exhibit VI.6
Screening Ratio for EPSDT Services- 2004



HEDIS Measures

Indiana's OMPP required each of its MCOs to report on 26 unique HEDIS measures. The NCQA, which developed the HEDIS, provides a definition for each measure which all health plans follow when reporting their data. Many measures are consistent across years to allow for longitudinal studies.

The HEDIS 2006 report that each MCO delivered to the OMPP was based on data from 2005. Because CareSource and Molina health plans were new to Indiana's Hoosier Healthwise program in 2005, there was not enough data for them to report on all HEDIS measures.

Nine of the 26 measures are specific to children's access and utilization, including:

(1) Childhood Immunization Status
(2) Adolescent Immunization Status
(3) Appropriate Treatment for Children with Upper Respiratory Infection
(4) Appropriate Testing for Children with Pharyngitis (strep throat)
(5) Use of Appropriate Medications for People with Asthma
(6) Children's Access to Primary Care Practitioners
(7) Well Child Visit in the First 15 Months of Life
(8) Well Child Visit in the 3rd through 6th Years of Life
(9) Adolescent Well-Care Visit

Each measure is discussed below. The findings for each MCO are compared against each other as well as the NCQA median value (50th percentile) across all health plans that submitted data on the measure in 2004. When discussing findings among the MCOs, the "older" plans refer to MDWise, MHS, and Harmony since they were under contract with OMPP prior to 2005. The "newer" plans are CareSource and Molina since they began on January 1, 2005.

Immunization Measures

The HEDIS measures for immunizations report on each immunization separately as well as a "combination" measure which encompasses administering multiple immunizations. The Combination Two measure reported on below includes:

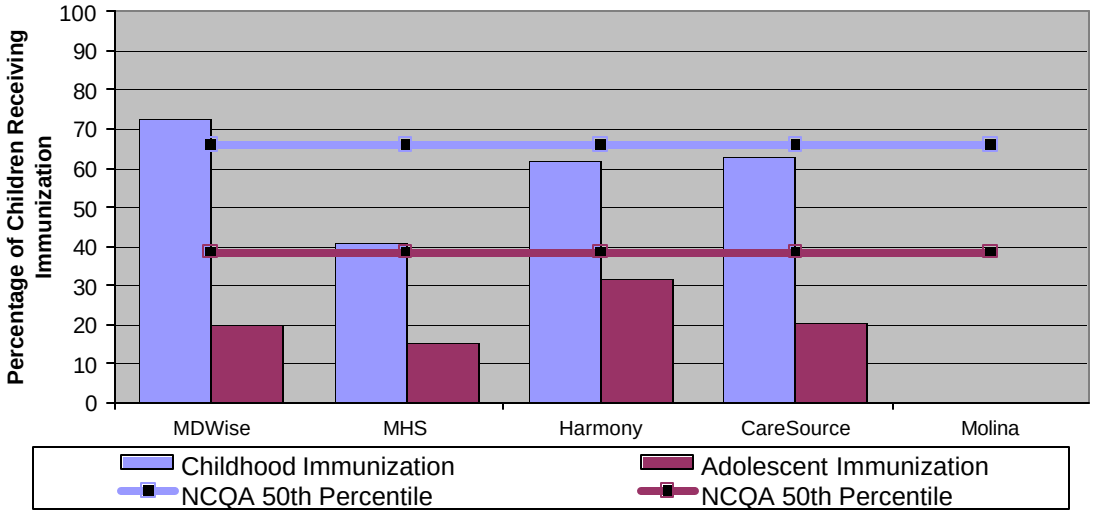
Four doses of diphtheria-tetanus	Three doses of influenza
Three doses of polio	Three doses of Hepatitis B
One dose of measles-mumps-rubella	One dose of chicken pox

Separate measures are collected depending upon the child's age. The Childhood Immunization measure includes children who turned age two during the measurement year who were enrolled for the 12 months prior to their second birthday. The Adolescent Immunization measure includes children who turned age 13 during the measurement year.

The exhibit below shows that MDWise, Harmony and CareSource are at or near the NCQA median of health plans nationwide for the Childhood Immunization measure. MHS is far below the median. All of Indiana's MCOs are below the national median on the Adolescent Immunization measure.

Among the older plans, MDWise and Harmony both improved their scores on the Childhood Immunization measure from 2004 to 2005, while MHS remained the same. All three MCOs posted modest gains on the Adolescent Immunization measure. After the results of the HEDIS 2005 study, the three older MCOs designed quality improvement projects to improve immunization rates. This appears to have had some success on the Childhood Immunization measure, but a continued targeted monitoring of these measures is recommended.

Exhibit VI.7
Rates for Combination Two Immunizations



Data not available for Molina health plan on this measure.

Appropriate Treatment for Upper Respiratory Infection and Testing for Pharyngitis

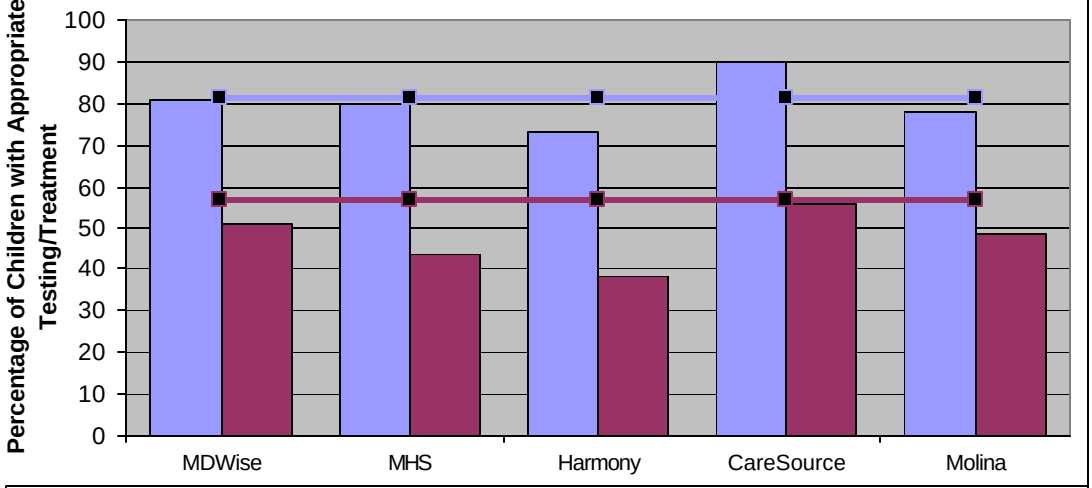
The upper respiratory infection measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable, because if an antibiotic was not given it means that the infection was treated more quickly.

The pharyngitis measure reports on the percentage of children between the ages of two and 18 who were diagnosed with strep throat, were prescribed an antibiotic, and who received a Group A streptococcus test. A higher rating is more favorable since it indicates better testing for those diagnosed with strep throat.

All of the MCOs had favorable ratings when compared to the NCQA median for the treatment of respiratory infections measure. Only CareSource matched the national median for the measure of appropriate testing for pharyngitis.

Among the older plans, MDWise and Harmony had a similar rating in 2004 and 2005 on the respiratory measure, while MHS showed considerable improvement. For the pharyngitis measure, Harmony reported a significant improvement from 2004 to 2005, MHS reported a modest improvement, and MDWise reported a modest decrease on this measure.

Exhibit VI.8
Rates for Treatment of Respiratory Infections & Testing Pharyngitis

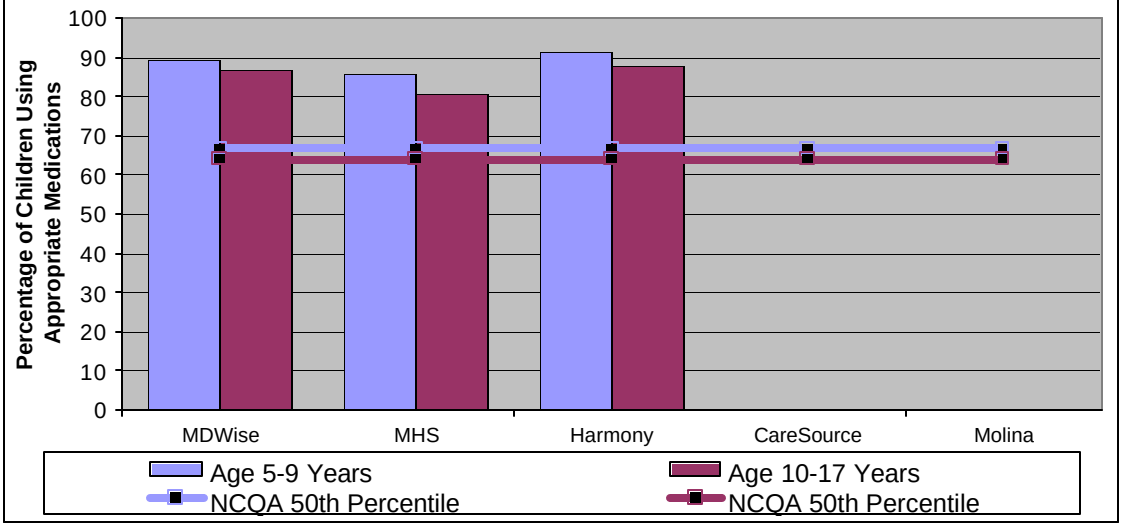


Use of Appropriate Medications for People with Asthma

This HEDIS measure reports on the percentage of members who were identified as having persistent asthma and who were prescribed appropriate medication. The measure is subdivided into three population groups: age 5-9 years, age 10-17 years, and age 18-56 years. The two child groups are reported below.

All three of the older plans had ratings above the national NCQA median in 2005. This is considerable improvement from the 2004 ratings. This stems from the MCOs' involvement in an OMPP-sponsored Best Clinical and Administrative Practices initiative designed to improve the ratings on this measure.

Exhibit VI.9
Use of Appropriate Medications for People with Asthma



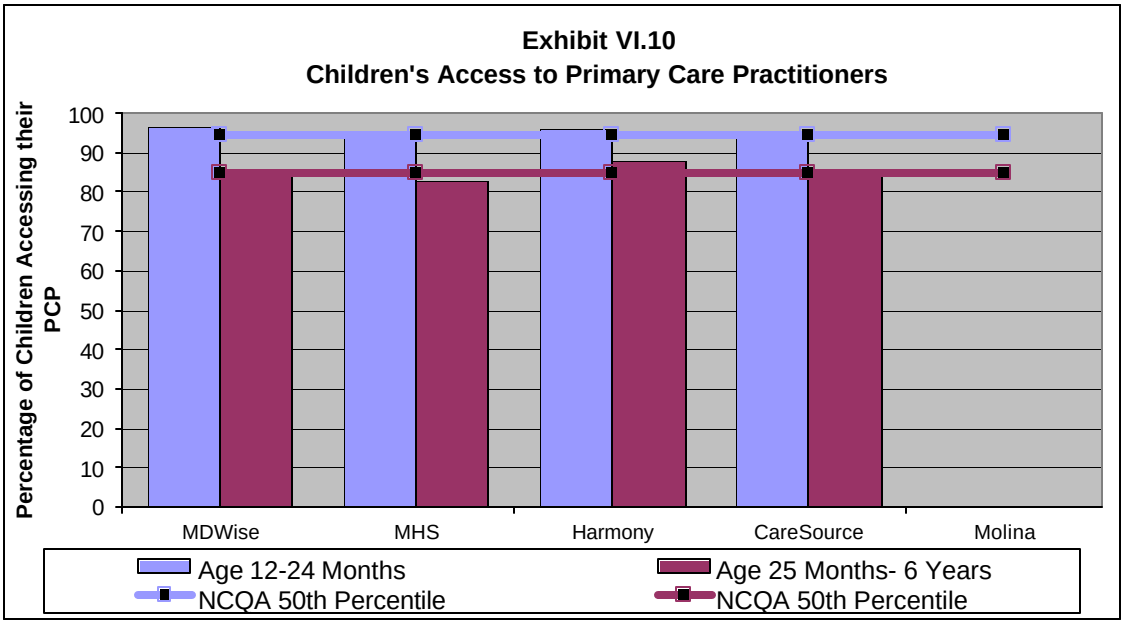
Data not available for CareSource or Molina health plans on these measures.

Children's Access to Primary Care Practitioners

This measure reports the percentage of children who had a visit with their primary care practitioner (called PMPs in Indiana) in the measurement year. Separate measures are conducted for four age groups: 12-24 months, 25 months-6 years, 7-11 years, and 12-19 years.

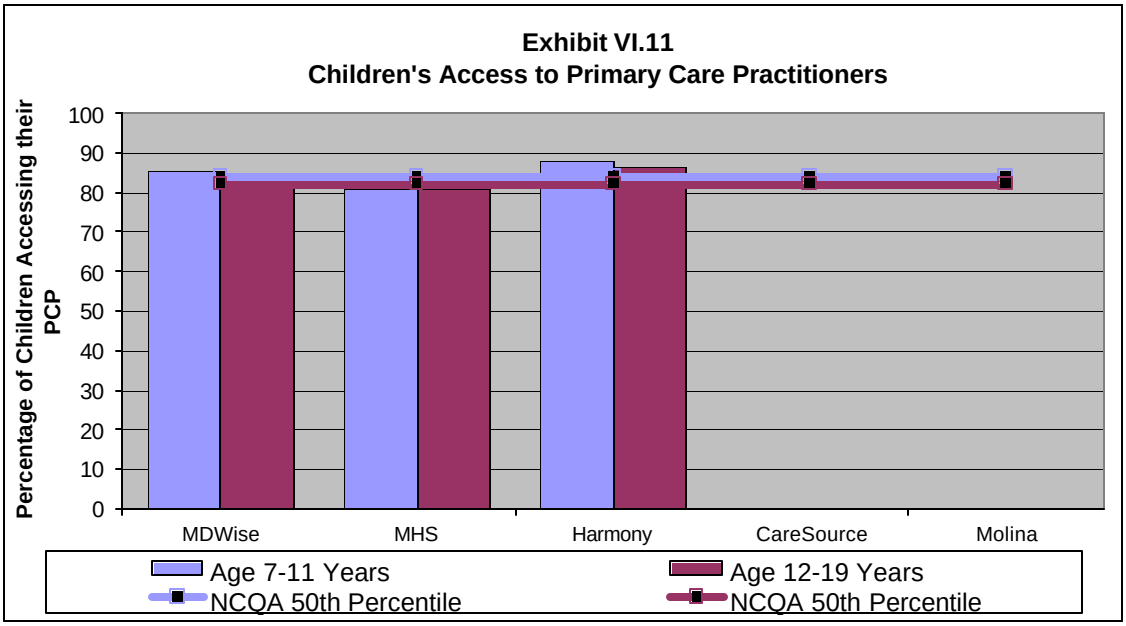
All MCOs reporting data were found to be at the NCQA medians for all age groups.

Exhibit VI.10
Children's Access to Primary Care Practitioners



Data not available for Molina health plan on these measures.

Exhibit VI.11
Children's Access to Primary Care Practitioners



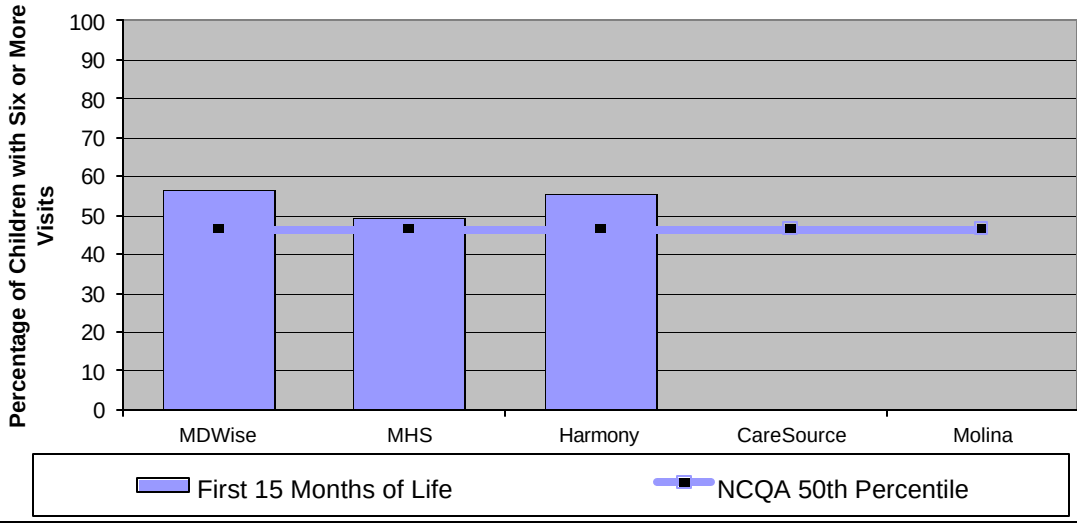
Data not available for CareSource or Molina health plans on these measures.

Well Child Visits in the First 15 Months of Life

This measure reports the percentage of children who turned 15 months old during the measurement year and received well child visits with a primary care practitioner in their first 15 months of life. A separate percentage is computed for the number of actual visits. The exhibit below compares Indiana's MCOs to the national median for the percentage of children with six or more visits.

All MCOs reporting on this measure had ratings at or above the NCQA median. Each MCO also improved on their rating from 2004.

Exhibit VI.12
Well Child Visits (Infants)



Data not available for CareSource or Molina health plans on this measure.

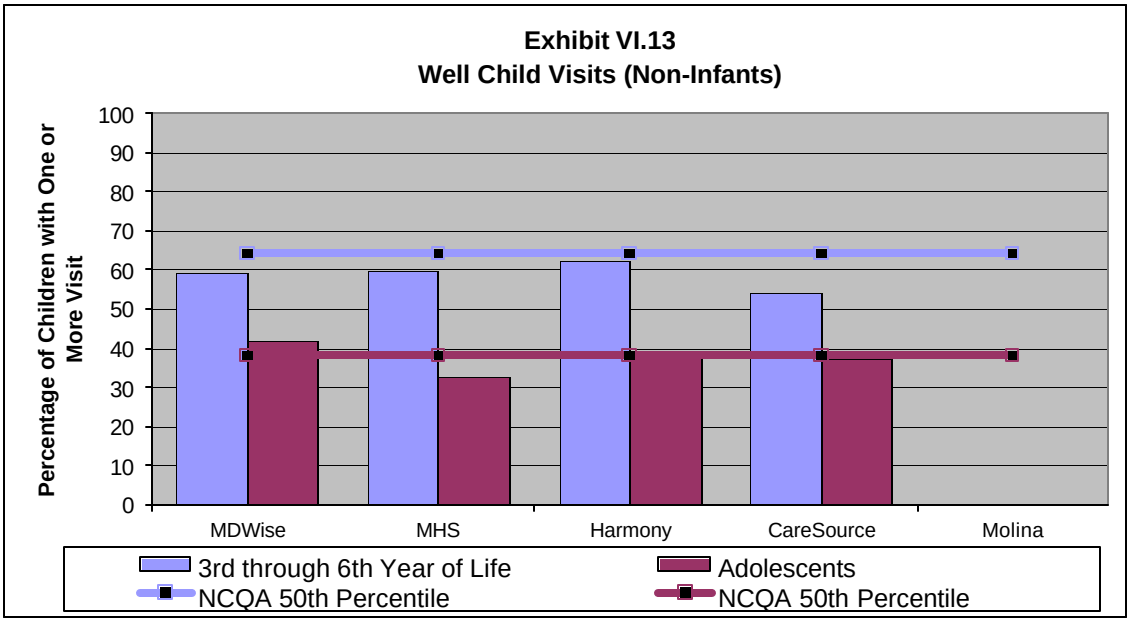
Well Child Visits (Non-Infants)

Separate ratings are measured for the percentage of children that had one or more well child visit during the measurement year for two age groups–children in their 3rd through 6th years of life and adolescents aged 12 to 21 years. For the adolescents, a visit to an OB/GYN also counts as a primary care visit.

Each of Indiana's MCOs had ratings slightly below the NCQA national median for the measure of younger children, but all except MHS met the NCQA median rating for the measure of adolescents.

Among the older plans, all three improved their rating for the younger children from 2004 to 2005. MDWise and MHS improved their adolescent measure slightly, but Harmony's rating decreased two percentage points.

Exhibit VI.13
Well Child Visits (Non-Infants)



Data not available for Molina health plan on these measures.

CAHPS Medicaid Child Member Satisfaction Survey

Each of the five MCOs reported their results from the Medicaid Child satisfaction survey. Results discussed below reflect all children in Hoosier Healthwise and are not CHIP-specific.

There were 8,777 surveys administered in 2006 with an overall response rate statewide of 29%. Response rates by MCO ranged from a low of 19% (MHS) to a high of 37% (CareSource). Demographic information of the respondents was evaluated across the MCOs to measure the consistency of those that responded. This information was also compared to the national CAHPS database of respondents to the 2005 Medicaid Child survey.

The distribution of respondents was similar across the MCOs by age group and gender when compared to the statewide average (see exhibit on next page). Indiana's respondents were also similar to the national dataset based on gender (information by age not available nationally). There were differences in the distribution of respondents when measured by race, but this may be due more to the geographic areas and populations each MCO serves rather than adverse selection.

The 76-question CAHPS survey asks a variety of questions related to the member's satisfaction with quality and accessibility of the care they are receiving from the health plan. The Myers Group, the survey administrator for all five MCOs, summarized the responses from multiple questions in the survey using a CAHPS protocol to develop overall composite ratings for each MCO. The composite ratings can be compared to a statewide average and the CAHPS national 2005 survey averages. Details by MCO and composite measure appear on page VI-16, but the summary of findings showed:

- Indiana's statewide average satisfaction ratings exceeded the CAHPS national averages on eight of the nine composite measures, with the only measure lower than national average being *Customer Service* (67.9% favorable for Indiana's MCO versus 72.1% for national).

- On four of the nine composite measures, some Indiana MCOs had ratings higher (using statistical significance) than the national average. MHS and MDWise were higher on the *Getting Needed Care* measure. Harmony and CareSource were higher on the *Getting Care Quickly* measure. MDWise and Harmony were higher on the *How Well Doctors Communicate* measure. MDWise was also higher on the *Courteous and Helpful Office Staff* measure.

- Only one health plan (Molina) was statistically lower than the national average rating on a measure. For Customer Service, Molina had a favorable rating of 61.7% versus the national average of 72.1%.

Exhibit VI.14
Summary of Demographic Information from 2006 Member Surveys

	MHS	MDWise	Harmony	CareSource	Molina	Statewide
Responses	368	606	434	584	541	2,533
Mail	298	372	295	399	344	1,708
Phone	70	234	139	185	197	825
Response Rate	19.0%	29.6%	27.1%	36.6%	33.9%	28.9%
Total Surveyed	1,937	2,047	1,601	1,596	1,596	8,777

	MHS	MDWise	Harmony	CareSource	Molina	Statewide Weighted Average	CAHPS 2005 Average
Age of Respondents' Children							
0-4 Years	31.5%	36.0%	28.5%	36.6%	29.3%	32.8%	not available
5-8 Years	22.2%	20.8%	24.6%	22.7%	20.9%	22.1%	not available
9-13 Years	26.4%	22.9%	27.8%	21.6%	27.9%	25.0%	not available
14 Years and older	19.9%	20.3%	19.1%	19.2%	21.9%	20.1%	not available
Gender of Respondents' Children							
Female	45.1%	47.8%	49.0%	47.7%	50.1%	48.1%	48.6%
Male	54.9%	52.2%	51.0%	52.3%	49.9%	51.9%	51.4%
Race/Ethnicity of Children							
White	67.0%	55.8%	76.7%	85.9%	84.7%	74.1%	58.6%
Black/African American	20.0%	31.0%	16.2%	8.0%	9.8%	17.0%	24.7%
Hispanic/Latino	7.2%	10.6%	8.7%	4.5%	3.8%	6.9%	14.0%
Asian	1.7%	0.9%	0.7%	1.7%	0.5%	1.1%	3.1%
Other	11.2%	12.3%	6.4%	4.5%	4.9%	7.8%	13.6%

Exhibit VI.15
Summary of Responses from 2006 Member Surveys

	MHS	MDWise	Harmony	CareSource	Molina	Statewide Weighted Average	CAHPS 2005 Average
Getting Needed Care	84.3%	83.6%	82.1%	80.9%	78.7%	81.8%	79.4%
Getting Care Quickly	82.1%	82.1%	86.3%	83.6%	82.7%	83.3%	78.7%
How Well Doctors Communicate	92.1%	93.3%	93.4%	92.1%	90.0%	92.2%	90.1%
Courteous and Helpful Office Staff	91.3%	93.6%	93.5%	92.6%	91.2%	92.5%	90.9%
Customer Service	65.8%	72.1%	61.8%	75.0%	61.7%	67.9%	72.1%
Rating of Personal Doctor	77.8%	85.1%	84.2%	84.4%	79.3%	82.5%	81.1%
Rating of Specialist	84.1%	80.9%	83.5%	81.0%	81.0%	81.9%	75.7%
Rating of Health Care	84.3%	83.5%	85.1%	86.1%	78.8%	83.5%	80.8%
Rating of Health Plan	77.1%	83.2%	81.9%	87.0%	66.7%	79.4%	77.6%

indicates results that are significantly higher statistically than the CAHPS 2005 average

indicates results that are significantly lower statistically than the CAHPS 2005 average

Getting Needed Care measures those that responded "not a problem" regarding attempting to get care for their child from doctors/specialists.

Getting Care Quickly measures those that responded "always" or "usually" regarding getting care in a reasonable time (includes office waiting room time).

How Well Doctors Communicate measures those that responded "always or "usually" when asked how well providers listen, explain, spend enough time with, and show respect for members.

Courteous and Helpful Office Staff measures those that responded "always" or "usually" regarding member's treatment by office staff.

Customer Service measures those that responded "not a problem" regarding their ability to find or understand information.

The percentages for the ratings for *personal doctor* , *specialist* , *health care* , and *health plan* reflect the number that gave a rating of 8, 9, or 10 on a scale of 1-10 with 10 being "best possible".

VII. Expenditures in Indiana's CHIP

Chapter Highlights

- Total payments made by the State for services for children in the premium-based portion of CHIP (CHIP C) were flat in CY 2006. Payments for children in the no-premium portion of CHIP (CHIP A) increased 9% in CY 2006.

- On a per member per month (PMPM) basis, CHIP C children have cost the State about 20% less than CHIP A children in the last three years. But CHIP A children are also 20% less costly than children in traditional Medicaid.

- When accounting for the portion of expenses that the federal government contributes to Indiana's CHIP, the state share on a PMPM basis for CHIP C was $27.19 and $34.80 for CHIP A in CY 2006. This compares to $62.22 for Medicaid children, which are higher both because they utilize more expensive services and because the federal government contributes less for this group.

- When accounting also for the premiums paid by families of children in CHIP C, the final cost to the State for this group was only $19.88 on a per member per month basis.

- In CY 2004, two-thirds of all payments made for CHIP services were on a fee-for-service basis. In CY 2006, two-thirds of all payments were made on a capitated per member per month basis through the Risk-Based Managed Care (RBMC) delivery system. Key services that were still made on a fee-for-service basis were dental and behavioral health related services. Starting in 2007, however, behavioral health services will also be part of the RBMC monthly capitation payment.

Payments for services to CHIP members are made by two primary mechanisms:

(1) Services delivered by MCOs and paid by the State through a per member per month basis (also known as a capitation payment).
(2) Services delivered on a fee-for-service, or individual claim basis. These would include services offered to CHIP members for which the MCOs are not responsible for delivering and not reflected in the capitation payment.

As Indiana's Hoosier Healthwise has moved to statewide managed care, the payments made under the CHIP have also moved more towards the capitation arrangement. In CY 2006, 60% of CHIP A expenditures and 64% of CHIP C expenditures were made under the RBMC capitation arrangement. Just two years ago, 70% of payments were being made under the fee-for-service arrangement.

Exhibit VII.1
Trends in Expenditures for CHIP A and CHIP C

	CHIP C CY06	Pct	CHIP C CY05	Pct	CHIP C CY04	Pct
Monthly Per Member Payments Made to MCOs	$14,539,117	64%	$10,883,274	48%	$6,156,438	30%
Payments Made on a Per Claim Basis	$8,121,372	36%	$11,694,368	52%	$13,817,927	68%
Other (PCCM Admin Fees)	$0	0%	$111,738	0%	$221,388	1%
Total Payments	$22,660,489	100%	$22,689,380	100%	$20,195,753	100%
Increase from Previous Year	-0.1%		12.3%			

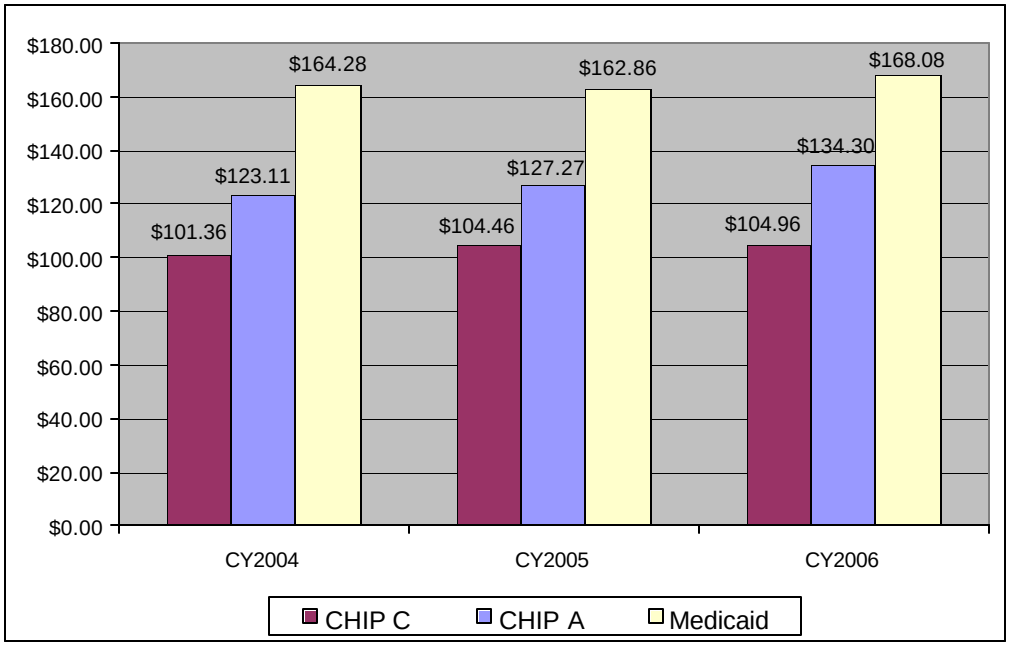
	CHIP A CY06	Pct	CHIP A CY05	Pct	CHIP A CY04	Pct
Monthly Per Member Payments Made to MCOs	$51,076,920	60%	$36,367,387	47%	$20,476,804	29%
Payments Made on a Per Claim Basis	$33,718,852	40%	$41,183,381	53%	$49,995,575	70%
Other (PCCM Admin Fees)	$0	0%	$315,204	0%	$667,401	1%
Total Payments	$84,795,772	100%	$77,865,972	100%	$71,139,780	100%
Increase from Previous Year	8.9%		9.5%			

As discussed in Chapter II, average annual enrollment in CHIP C was flat (-0.6%) in 2006 when compared to 2005. Expenditures were also flat even though some increase in expenditures is expected for medical inflation costs. Average annual enrollment in CHIP A grew 3.2% in 2006 but expenditures increased 8.9% during the year.

To account for enrollment fluctuations, expenditures are often measured over time on a per member per month (PMPM) basis. The exhibit on the next page shows the changes in the PMPM cost for children in CHIP C, CHIP A, and Medicaid. What is important to note is that the PMPM cost for CHIP C (the premium portion) has always been and continues to be lower than that of CHIP A (the non-premium portion). This is true despite the fact discussed in Chapter IV that the percentage of CHIP C children accessing services is higher than that in CHIP A. The PMPMs for CHIP C have been about 20% lower than those for CHIP A in the last three years. But, like CHIP C, CHIP A has PMPM costs lower than those found for Medicaid children. Further, the CHIP C PMPM grew only 0.5% in CY 2006, as compared to 5.5% for CHIP A and 3.2% for Medicaid children.

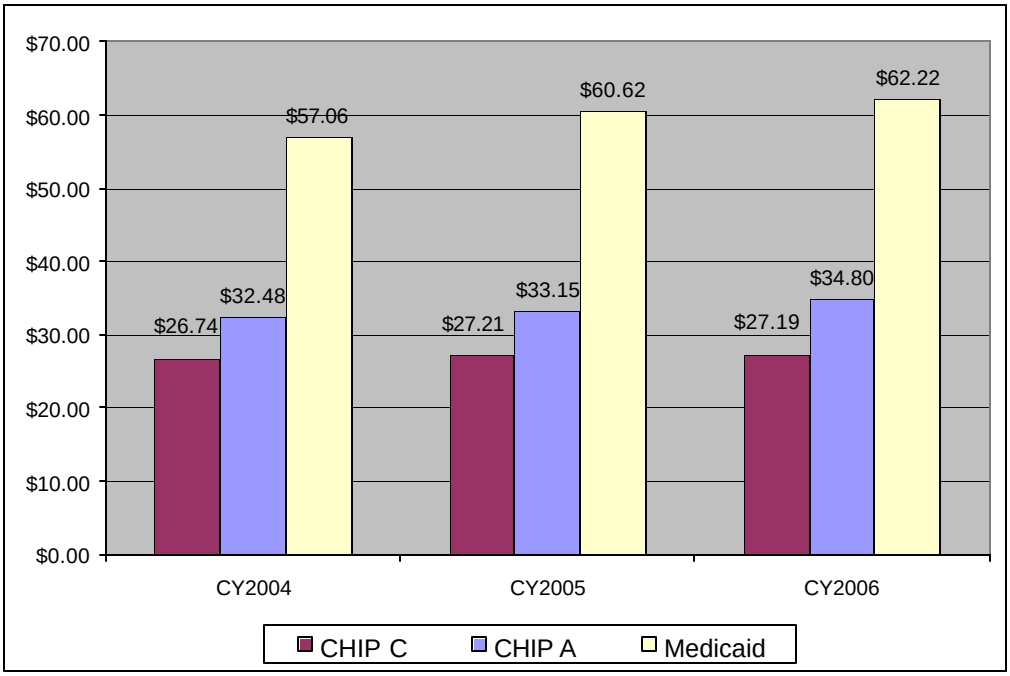
The bottom exhibit on the next page shows that, after accounting for federal contributions to Indiana's CHIP, the PMPM cost to the State for CHIP C members was $27.19 per month in 2006 and was $34.80 per month for CHIP A members. The CHIP C PMPM has increased less than 50 cents over the last three years.

Exhibit VII.2
Trends in the Cost Per Member Per Month (PMPM)
Total Federal and State Share



Note that CHIP C costs are not offset by premiums paid by members.

Exhibit VII.3
Trends in the Cost Per Member Per Month (PMPM)
State Share Only



Note that CHIP C costs are not offset by premiums paid by members.

The costs to the State for CHIP children are lessened by a higher federal contribution for CHIP programs than traditional Medicaid programs. For example, in Federal Fiscal Year 2006, the federal government paid 74.09 cents of every dollar spent on CHIP children, but 62.98 cents of every dollar spent on Medicaid children. The costs of the CHIP C program are further reduced by the offset of premium revenue paid by families. In February 2006, premium rates were doubled. As a result, in CY 2006 the State collected $6.1 million in premium revenue. This resulted in a net cost to the State of only $19.88 PMPM for each CHIP C member.

VIII. Recommendations to Indiana's CHIP

Burns & Associates (B&A) has reviewed the financing and costs of Indiana's CHIP as well as the method of delivering services to members and their corresponding access and use of services. Our overall impression is that the CHIP is meeting its goals of providing cost-effective services to children who, in the absence of the program, would most likely be uninsured and have an unmet need. This is the 7th evaluation that the authors have completed of Indiana's CHIP. We have identified specific areas that the Office of Medicaid Policy and Planning may want to pursue further with the aim of continually improving the access to and delivery of services to low-income children in the State. Some recommendations have been made in prior evaluations that merit repeating. Other recommendations are new in this year's evaluation.

Recommendations Related to Financing

(1) After the legislation to reauthorize the SCHIP at the federal level (expected to occur later this year), evaluate projected financing for Indiana's CHIP versus current financing. Changes in the financing mechanism (potentially through annual allocations or federal match rates) may offer Indiana new options to expand the current program.

(2) There appears to be a strong push from the Executive branch of the federal government to limit SCHIP to children in families with incomes up to 200% of the federal poverty level. This is how Indiana's CHIP is currently structured. Despite this limitation, B&A estimates that there are an additional 100,000 children in Indiana who would be currently eligible for CHIP. Depending upon future financing opportunities from the federal government, Indiana's CHIP is encouraged to develop a new outreach program built on the success of the original outreach efforts conducted in 1997-1998 to enroll these 100,000 children.

(3) Premiums charged to members enrolled in CHIP C were doubled in February 2006. Although this increase appears to be merited, the new premiums place Indiana's CHIP in the upper quartile among all states that charge premiums to members. With federal financing and the premiums charged that offset the costs, the cost of CHIP C members to the State was $19.88 per member per month in 2006. Since overall costs (on a PMPM basis) have grown only 50 cents in the last three years for CHIP C, B&A suggests that Indiana's CHIP keep the current premium rates constant for the foreseeable future.

Recommendations Related to Enrollment

(1) B&A found that 12% of children in CHIP A and 8% of children in CHIP C in 2006 remained in the Fee-for-Service delivery system beyond the standard policy of one month. This is based on our analysis of member enrollment

records recorded on a monthly basis. After one month, if members do not select a Primary Medical Provider (PMP) and a managed care organization (MCO), the State will automatically assign them to one. This does not appear to have occurred in every instance given the data available to us. We found similar situations like this in our analysis in prior years. Indiana's CHIP should research this further to determine if this is actually occurring or if the enrollment records are not complete in showing the MCO that the member is enrolled with.

(2) The CHIP may want to explore further why children are disenrolling from the program. Parents must reapply every 12 months to ensure that their children are still eligible for the CHIP. B&A did not see an obvious spike in disenrollments after a child has been enrolled for 12 months (implying that their parents did not reapply), but the State does not have sufficient documentation to track why members are leaving (e.g. parents obtained private insurance, parents' income has exceeded eligibility threshold, moved out of state, etc.).

(3) Early on in the program, Indiana's CHIP streamlined the eligibility process to avoid "red tape" to get children enrolled. This efficient system may be compromised somewhat by the new federal requirement to document citizenship of all members. Indiana's CHIP should continually monitor members who are due for renewal after 12 months to determine if they are following through with their applications.

Recommendations Related to Access

(1) Although B&A did not find a correlation between counties that have low PMP panel capacity (i.e. willingness to accept new members) and access to primary care services, we did find that the counties with full or near-full PMP panels were counties that had doctors who were not willing to accept as many Hoosier Healthwise members than what is recommended. Indiana's CHIP should develop targeted outreach with the MCOs to persuade or provide incentives to PMPs to increase their panel slots, particularly in areas with low pediatrician access.

(2) The State is encouraged to work with the MCOs to determine the rate at which CHIP members are seeing PMPs that are not assigned to them. In 2006, 72% of CHIP A members saw their assigned PMP while 27% saw another PMP at some point in the year. For CHIP C, the rates were 83% and 37%. This may or may not have been the same members seeing both types of PMP. B&A noticed that most of visits to an "unassigned" PMP were when members first enrolled and had yet been assigned to a PMP. However, 11% of all claims submitted by MCOs for PMP visits were when members saw a PMP they were not assigned to. Indiana's CHIP may want to study whether or not this is simply a data reporting issue (e.g. the member's assigned PMP is not listed on the claim visit) or if there is an

underlying access issue. To promote the continuity of care, members should see their assigned PMP for all non-specialized care.

(3) The rate of usage of the hospital emergency room was higher than we would have expected. It is unclear from the available data whether or not the usage is actually emergent or if the service could be delivered in a less intensive setting. In 2006, 40% of CHIP C members had a service in the ER; for CHIP A, it was 36%. B&A observed that many of the ER visits did not have one of the five ER procedure codes that normally are listed on an ER claim (no procedure code was listed in these cases). Indiana's CHIP should explore the specific types of services being submitted as ER services. If services being delivered are non-emergent, this may indicate an access issue for primary care or a need for education to divert away from the ER.

Recommendations Related to Service Utilization

(1) Indiana's CHIP should work with the MCOs to improve the rate of EPSDT visits. It is unknown at this time whether the low usage reported is due to actual low utilization or improper recording of an EPSDT visit. In 2006, only 43% of CHIP C members studied had an EPSDT visit; for CHIP A, it was 30%. The focus of the study should be on children ages 1-6, since the State recommends some type of EPSDT visit at 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, and 6 years of age. The MDWise MCO reported much higher EPSDT utilization for its CHIP members than the other MCOs. The CHIP may want to discuss any best practices conducted at MDWise that promotes these higher utilization rates.

(2) Although child immunization rates have been improving over the last few years for Hoosier Healthwise children in general, B&A recommends that ensuring and identifying immunizations for each child remain a high priority. The HEDIS measures reported annually by the MCOs suggest that most MCOs have seen marked improvement on the child immunization rate, but all MCOs were below the national median target last year for adolescent immunization rates. The issue may not be that the immunizations were not given as much as they were not reported. Indiana's CHIP should work closely with the MCOs to stimulate accurate reporting of immunizations.

(3) Access to PMP services (whether an assigned PMP or unassigned PMP) are also improving each year. There appears to be opportunities for continued improvement in the usage of PMP services among CHIP's youngest members aged 1-5. In CY 2006, 78% of CHIP A members enrolled at least nine months saw their PMP. For CHIP C, it was 83%.

Recommendations Related to Quality

(1) B&A specifically analyzed utilization patterns of CHIP children with asthma, behavioral health conditions, and obesity diagnoses. In the cases of all three diagnoses, the data showed that these children were twice as likely to use clinics, emergency rooms, inpatient hospital stays, outpatient hospital services, and prescription drugs. B&A suggests that Indiana's CHIP work closely with the MCOs to develop a protocol to identify these children so that targeted care management plans can be developed for them, particularly to prevent avoidable hospital and ER visits.

(2) For preventive care services, the CHIP should consider developing an ongoing monitoring plan which requires the MCOs to report how they are encouraging parents to seek well child visits and EPSDT visits for their children in CHIP.